

S. No. 2
M-8-43
V. 5-17-39
-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36371

State File No.

9563

FILED NOV 23 1944

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 months
In this community 0 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Edith Schaub

3. (b) If veteran, name war _____ 3. (c) Social Security number 702-14-2159

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 10 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 2 0 hr. min.

9. Birthplace St. Louis Mo. U
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk-Mo. Pacific R. R.

11. Industry or business _____

12. Name Charles Schaub

13. Birthplace Unknown U
(City, town, or county) (State or foreign country)

14. Maiden name Anna Jakerst

15. Birthplace Unknown U
(City, town, or county) (State or foreign country)

16. (a) Informant Frances Kriege

(b) Address 3441 S. Jefferson Ave.

17. (a) Burial (b) Date thereof Nov. 13, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Wacker Kelderle

(b) Address 3634 Gravois Ave.

19. (a) NOV 11 1944 (b) J. F. Bredeck
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 3441 S. Jefferson Ave. (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10 year 1944 hour 6 minute DOA M.

21. I hereby certify that I attended the deceased from 6/15/44, 19____, to 11/10/44, 19____; that I last saw her ex alive on 11/10/44, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinomatosis
Due to: Carcinoma of stomach 6 yrs
Due to: _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Carcinoma stomach
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature C. G. Dacey Jr. (M. D. or other) _____
Address 1755 N. Grand Date signed 11/10/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address St Louis mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.