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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 31 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 730

Registration District No. 218

Primary Registration District No. 1003

Registrar's No. 574

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Johns Hospital.  
 (If not in hospital or institution, write street number or location) 0  
 (d) Length of stay: In hospital or institution 3 weeks.  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Fred G. Schildknecht.

(b) If veteran, name war None (c) Social Security No. 490-01-0687

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

6. (b) Name of husband or wife Rose Schildknecht. 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased December 25, 1889.  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>0</u>	<u>24</u>	hr. min.

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

10. Usual occupation Steel worker.

11. Industry or business

MOTHER FATHER { 12. Name Karl Schildknecht. 4  
 13. Birthplace Germany.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Anna Marie Kern.  
 15. Birthplace Germany.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Otto G. Schildknecht. 1  
 (b) Address 2147 Erich Avenue.

17. (a) Cremation (b) Date thereof 1-20-1945.  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.  
 (b) Address 5966-68 Easton Avenue.

19. (a) JAN 19 1945 (b) J. F. Bredeck  
 (Date certified true) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County  
 (c) City or town Madison  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1312 State Street.  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18th.  
 year 1945 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from June, 1944, to January, 1945  
 that I last saw him live on January 18, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
Thrombosis  
 Duration 3 days  
2 wks

Due to General carcinoma  
of abdominal organs  
 Duration 1 year

Due to Adeno carcinoma  
of Colon (Lx)  
 Duration 10 m

Other conditions Ho  
 (Include pregnancy within 3 months of death)

Major findings: Adeno carcinoma  
of sigmoid colon

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) (c) Means of injury

23. Signature W. J. ... (M. D. or other) M.D.  
 Address: 1932 Maryland Date signed Jan 1945

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

Dr. S.H. Pranger.  
4952 Maryland Avenue.  
Hours 1.30 to 5 P.M.  
Rosedale 3062

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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

*Ben C. Hoffmann*

Licensed Embalmer No. *4364*

P. O. Address *Harris, Md*

**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.**