

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32334**
Registrar's No. **9262**

FILED NOV 2 1945

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis City Hospital**

(b) City or town **St. Louis City Hospital**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Max C. Starkloff Memorial**
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days**
(Specify whether)

In this community **44 years**
(years, months or days)

3. (a) PRINT FULL NAME **JOHN SCHARE**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **none**

4. Sex **male**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mrs. Frances Schare**

6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **November 20th. 1900**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
44	11	4	hr. min.

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

10. Usual occupation **Stock Clerk**

11. Industry or business **Fuller Co.**

MOTHER FATHER {

12. Name **John Schare**

13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Catherine Cummings**

15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Frances Schare**

(b) Address **1437a Warren St.**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **10-27-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Hy. Leidner U. Co.**

(b) Address **2223 St. Louis Ave.**

19. (a) **OCT 28 1945** (Date received)
J. H. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **26000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **1437a Warren St.**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **24**
year **1945** hour **8:30** minute **A** M.

21. I hereby certify that I attended the deceased from **October 21** 19**45** to **October 24** 19**45**
that I last saw h. **im** alive on **October 24** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **9 hypertensive heart disease**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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 **Herbert C. Zitz** (M. or other)
Address **1515 Lafayette Avenue** Date signed **10/24/45**

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

John P. Buchholz

Licensed Embalmer No. *1674*

P. O. Address *2423 St. Louis Ave*

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.