S. No. 2
M—2-43
7. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39760

FILED JAN 31 1946

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 11243

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: 1323 South Sixth Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 1323 South Sixth St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Schoenig

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Rose

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

7. Birth date of deceased Aug. (Month) 12 (Day) 1863 (Year)

8. AGE: Years 82 Months 4 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Unknown

MOTHER FATHER

12. Name _____

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

14. Maiden name Unknown

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

16. (a) Informant Julia Schoenig

(b) Address 1323 So. Sixth St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Walter Schlueter

(b) Address 3634 Gravois Avenue

DEC 22 1945

19. (a) _____ (Date received local registrar) (b) J. F. Bubek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20 year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from July, 1939, to Dec. 20th, 1945 that I last saw him alive on Dec. 20th, 1945: and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardio-nephritic.

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address 1319 So. Bdway. Date signed 12/21/45

(Licensed Embalmer's Statement on Reverse Side)

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 C. Wheeler

Licensed Embalmer No. 3128

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.