. S. No. 2
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v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 27 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10805

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 657

96
0
0

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

9717

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jennings
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8338 Hord Ave. 1
(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 St. Louis 96
(c) City or town Jennings 0
(If outside city or town limits, write "RURAL")
(d) Street No. 8338 Hord Ave. 0
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME Amond Schindler

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Julia Schindler
6. (c) Age of husband or wife if alive XXXX years

7. Birth date of deceased March (Month) 2 (Day) 1865 (Year)

8. AGE:

Years	Months	Days	If less than one day
81	0	14	..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Germany 1 (State or foreign country)
10. Usual occupation Farmer
11. Industry or business .....

FATHER
12. Name Aloysius Schindler
13. Birthplace ..... (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Magdaleine Fatter
15. Birthplace ..... (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Rita Schulelein
(b) Address 8338 Hord Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46 (Month) (Day) (Year)
(c) Place: burial or cremation Perryville, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 3-20-46 (Date received local registrar) (b) E.G. McGarrant M.D. (Registrar's signature) BSC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
year 1946 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from Feb. 20, 1946, to Mar. 16, 1946
that I last saw him alive on Mar. 14, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis 1	?
Due to 93	
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? ..... (Specify type of place)
While at work? — (e) Means of injury .....

23. Signature Albert Wall (M. D. or other) M.D.
Address 5322 Helen Ave. Date signed 3/18/46

(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.....Elmer W. Sadwell.....

Licensed Embalmer No.....4077.....

P. O. Address.....

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.