

FILED JUN 26 1946
318

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute to City Hosp #1 3
(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 **Mo** (b) County **000**
(c) City or town **St. Louis** **1519**
(If outside city or town limits, write "RURAL")
(d) Street No. **3325 Itaska St**
(If rural, give location) **9**
(e) Citizen of foreign country? _____ (Yes or No) **3**
If yes, name country _____

3. (a) PRINT FULL NAME **Clyda W Scharringhausen**

3. (b) If veteran, name war **World War # 1** 3. (c) Social Security No. **489 10 2369**

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

6. (b) Name of husband or wife **Sophia** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **May 1 1896**
(Month) (Day) (Year)

8. AGE: Years **50** Months **1** Days **15** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Auditor**

11. Industry or business **Moloney Ele Co**

12. Name **William Scharringhausen**

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

14. Maiden name **Anna Stein**

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

16. (a) Informant **Sophia Scharringhausen**

(b) Address **3325 Itaska St**

17: (a) **Burial** (b) Date thereof **6 19 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Cemt**

18. (a) Signature of funeral director **Kriegshausner**

(b) Address **4228 So. Kingshighway**

19. (a) **JUN 17 1946** (Date received local registrar) **J. F. Bredeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **16**
year **1946** hour **7:30** minute **20** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Endocarditis Recurrens

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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) _____
Means of injury _____

23. Signature **Alfred Perry** (M. D. or other) **3**
Address **Capitol Plaza** Date signed **6/17/46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 Edwin R. McDermott

Licensed Embalmer No. 3024

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.