

S. No. 2  
DM-2-43  
v. 5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

**FILED** AUG 20 1946

STANDARD CERTIFICATE OF DEATH

28365 0'

State File No. \_\_\_\_\_

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1692

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Des. Peres

(c) Name of hospital or institution: None, Blace Ave.  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: in hospital or institution None  
(If not in hospital or institution, write street number or location)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 91

(c) City or town Des. Peres  
(If outside city or town limits, write "RURAL")

(d) Street No. Blace Ave.  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Henry Schaefer

(b) If veteran, name war None

(c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 13  
year 1946 hour 11:00 minute \_\_\_\_\_ P.M.

4. Sex Male 5. Color or race White

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

(b) Name of husband or wife Margaret Schaefer (c) Age of husband or wife if alive 18 1/2

7. Birth date of deceased Apr. 20. 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 11, 1946, to August 13, 1946, that I last saw him alive on August 13, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 days

8. AGE: Years 80 Months 3 Days 23  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Hypertension

Due to Arteriosclerosis

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

Other conditions Terminal bronchopneumonia 1 day  
(Include pregnancy within 3 months of death)

10. Usual occupation Retired Farmer

Major findings:  
Of operations \_\_\_\_\_

MOTHER FATHER

11. Industry or business Own farm.

12. Name Balzer Schaefer

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

14. Maiden name Barbara Mueller

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

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_  
(b) Address Kirkwood Mo. R.R. - 13

17. (a) Burial (b) Date thereof Aug. 16 - 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Trinity Cem. Althem Mo.

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? 3

18. (a) Signature of funeral director Schrader Funeral Home  
(b) Address Ballerwin, Mo.

19. (a) 8-16-46 (b) E. D. McFarlan  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

Signature B. P. Loving (M. D. or other) m.d.

Address Ballerwin, Mo. Date signed 8-17-46

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

6  
0  
0

27204

**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

*Theo. Schuder*

Licensed Embalmer No.

*3066*

P. O. Address

*Ballwin, 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.**