

**FILED** SEP 9 1946  
Registration District No. 318

Primary Registration District No. \_\_\_\_\_

Registrar's No. 2464

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

27884

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 \_\_\_\_\_  
5473 Ruskin Ave.  
(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

3. (a) PRINT FULL NAME Christine Schopfer

3. (b) If veteran, name war \_\_\_\_\_ No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if Single years

7. Birth date of deceased: August 27, 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

76	0	1	_____ hr. _____ min.
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9. Birthplace: New Athens, Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business House Work

MOTHER FATHER { 12. Name John H. Schopfer

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

{ 14. Maiden name Caroline Herr

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

16. (a) Informant Miss Josephine Schopfer

(b) Address 5473 Ruskin Ave.

17. (a) Burial (b) Date thereof Aug. 31 '46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bromschwig Funeral Home

(b) Address 4746 W. Florissant Ave.

19. (a) AUG 29 1946 J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

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. 5473 Ruskin Ave.  
(If rural, give location)

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28 year 1946 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 8-11-46 19 to 8-20-46 19

that I last saw her alive on 8-20-46 19 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myeloid leukemia

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? \_\_\_\_\_

23. Signature Albert A. [unclear] (M. D. or other) \_\_\_\_\_

Address 7210 Lind Bridge Date signed 8-20-46

Physician

Underline the cause to which death should be charged statistically.

STATE OF MISSISSIPPI

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**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 W Wilkinson  
Licensed Embalmer No. 3575  
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.**