

FILED SEP 3 1946

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

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4710 Varrelmann 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 Life,  
years, months or days)

3. (a) PRINT FULL NAME Barbara Schroll,

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 Widowed

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

7. Birth date of deceased December 31, 1856  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
89 7 21  
hr. \_\_\_\_\_ min.

9. Birthplace Baltimore Md.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business \_\_\_\_\_

12. Name John Schmitt,

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

14. Maiden name Elizabeth Klump,

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

16. (a) Informant Louise Blase,

(b) Address 4710 Varrelmann,

17. (a) Burial (b) Date thereof 8/26/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old SS Peter & Paul

18. (a) Signature of funeral director Oscar J Hoffmeister

(b) Address 4016 Chipewa,

19. (a) AUG 26 1946 J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 1517  
(d) Street No. 4710 Varrelmann, (If rural, give location) 9  
(e) Citizen of foreign country? No (Yes or No) 9  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22  
year 1946 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 1946,  
that I last saw her alive on Aug 21, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage  
Due to Arterio Sclerosis  
Duration \_\_\_\_\_

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? 50

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

23. Signature J. F. Bredeek M. D. or other \_\_\_\_\_  
Address 4724 Bredeek Date signed 8/24/46

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

MOTHER FATHER

2134

**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. 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.**