

No. 2
12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35582**
Registrar's No. **8942**

Registration District No. **318** Primary Registration District No. **1003**

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:
4983 Loughborough 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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4983 Loughborough Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Schreit
(b) If veteran, name war None
(c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Katherine
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Sep't. 15 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 1 2 hr. _____ min.

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

10. Usual occupation Shoe Cutter

11. Industry or business _____
12. Name Matthew Schreit
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Pokorny
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Katherine Schreit
(b) Address 4983 Loughborough Ave.

17. (a) Burial (b) Date thereof 10 21 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park
18. (a) Signature of funeral director Kriegshauser Und. Co.
(b) Address 4228 So. Kingshighway Bl.

19. (a) OCT 18 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

1003

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17th
year 1946 hour 10:00 minute _____ P. M.
21. I hereby certify that I attended the deceased from Oct. 4, 1946
19____ to Oct. 17, 1946
that I last saw him alive on Oct. 17, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension - C.V. Disease Duration 1 Mo.?
Due to arteriosclerosis ?

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 Lew Welsh (M. D. or other) M.D.
Address 4030 Phoureaux ave Date signed 10/18/46

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

MOTHER FATHER

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..... *Richard W. Stovessand*

Licensed Embalmer No. *4007*

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.