

S. No. 2
FORM-5-43
Rev. 5-17-39
X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39060**
Registrar's No. **9907**

FILED DEC 2 1948
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Park Lane Hospital
(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 Ruth Schmidt
3. (b) If veteran, name war No
3. (c) Social Security No. 495-16-0735

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edwin Schmidt Sr
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased July 27 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 3 20 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Arcus Candle

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

14. Maiden name Annie Duffy

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

16. (a) Informant Edwin Schmidt Sr

(b) Address 5976 a Romaine Place

17. (a) Burial (b) Date thereof 11 21 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave

19. (a) NOV 20 1948 (b) J. F. Buresch
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5976 a Romaine Place
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 17.
year 1946 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from 11/11/46 19, to 11/17/46 19,
that I last saw her alive on 11/17/46 19,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of liver
Due to Carcinoma of Rt. breast 2 yrs

Due to H67
Other conditions
(Include pregnancy within 3 months of death)

Major findings: Ca. of liver - CODE
Of operations
Of autopsy Ca. of liver

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)
(e) Means of injury
23. Signature G. William Pohl, M.D. (M.D. or other)
Address 5101 Delmar BL Date signed 11/17/46

Duration 4 mo
PHYSICIAN
Underline the cause to which death should be charged statistically.

Dr G. William Poehl
5101 Delmar

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..... *Alfred J. Boedeker*
.....
Licensed Embalmer No. 2663.....

P. O. Address. 1125 Hodiament Ave.....

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.