

FILED JAN 31 1947

Registration District No. _____

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Manchester Nursing Home & Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11/22/46 to 12-30-46
In this community 11/22/46 to 12/30/46 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Ferguson
(If outside city or town limits, write "RURAL")
(d) Street No. 25 Macchir
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Schonde

3. (b) If veteran, name war _____ 3. (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 Mary Schonde
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased 9 10 1864
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 20
If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Railway Laborer

11. Industry or business Railway

MOTHER FATHER { 12. Name Frank Schonde
13. Birthplace Germany
14. Maiden name Frances Unknown
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Schonde
(b) Address Ferguson, Missouri

17. (a) Burial (b) Date thereof 1/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Laurel Hill Gardens

18. (a) Signature of funeral director White Funeral Home
(b) Address Ferguson Mo

19. (a) 1-4-46 (b) Arthur Allen MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30
year 1946 hour 1 minute P M.
21. I hereby certify that I attended the deceased from Nov. 22
1946, to Dec 30, 1946
that I last saw him alive on Dec 28, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis
Due to Genl arteriosclerosis
Due to 93D
Other conditions Smoking
(Include pregnancy within 3 months of death)

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

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? (C)
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature PH Denny (M. D. or other) MD
Address Crede Cochr, Mo Date typed 1-2-47

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 *L. M. Shulte*

Licensed Embalmer No. *3993*

P. O. Address *Jerguson, Ga*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.