

S. No. 2  
DM-5-43  
v. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 24 1947**  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. \_\_\_\_\_  
Registrar's No. 1557

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

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:  
1147 HODIAMONT AVE 1  
(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 Mad  
(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1147 HODIAMONT AVE  
(If rural, give location) 9  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARGARET M. SCHROEDER  
(b) If veteran, name war No  
(c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 12<sup>th</sup>  
year 1947 hour 5 minute P M.  
21. I hereby certify that I attended the deceased from  
Sept 2, 1940, to Feb 12, 1947  
that I last saw her alive on 2-10, 1947  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife JOSEPH H.  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: MARCH 2 1869  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage  
Due to Chronic Myocarditis  
Due to Generalized Arteriosclerosis  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
77 11 10 hr. min.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
93

9. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

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

12. Name FRANK G. GALVIN

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

14. Maiden name MARY BRENNAN

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

16. (a) Informant Bertine Schroeder

(b) Address 1147 HODIAMONT

17. (a) BURIAL (b) Date thereof 2-15-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen & Kelly

(b) Address 7267 NATURAL BRIDGE

19. (a) FEB 14 1947 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

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 W. E. Moore M.D. (M. D. or other) MD  
Address 7301 Natural Bridge Rd Date signed 2-13-47

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

MOTHER FATHER

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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 Albert Mayfield

Licensed Embalmer No. 13077

P. O. Address. St Louis Mo

**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.**