

No. 2
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5-17-39
P 1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1237

FILED FEB 17 1947 318

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County MISSOURI
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. JOHN'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME NICHOLAS A. SCHROEDER
3. (b) If veteran, name war _____ 3. (c) Social Security No. 494-07-5672

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife NELLIE 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased FEB. 3 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 0 1 hr. min.

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

10. Usual occupation PARK EMPLOYEE

11. Industry or business ST. LOUIS CITY PARKS

12. Name ANDREW SCHROEDER

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

14. Maiden name ELIZABETH KIEFER

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

16. (a) Informant NELLIE SCHROEDER

(b) Address 2308 PESTALOZZI

17. (a) BURIAL (b) Date thereof FEB 7 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLD S. S. PETER & PAUL

18. (a) Signature of funeral director Thomas Kuti's son

(b) Address 2906 GRAVOIS

19. (a) FEB 6 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 24000
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17
(d) Street No. 2308 PESTALOZZI (If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 4
year 1947 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from Jan 25 1947 to Feb 4 1947
that I last saw him alive on Feb 4 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative Respiratory failure Duration 7 1/2
after Pharyngeal laryngectomy

Due to Bronchial Asthma? years
for unknown no. of yrs

Other conditions Prostatic Hypertrophy
(Include pregnancy within 3 months of death)

Major findings: Prostatic Hypertrophy
Of operations _____

Of autopsy Emphysema of lungs
atrophy left kidney.

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? _____

(e) Means of injury _____ (Specify type of place)

23. Signature Charles R. Anderson, M.D. (M. D. or other)
Address 609 Humboldt Bldg Date signed 2/6/47

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

MOTHER FATHER

1800 St. Louis, Mo.
11 St. 530
-Helen ...
-King ...

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 Leo Budde
Licensed Embalmer No. 3989
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.