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DEPARTMENT OF HEALTH
BUREAU OF THE CENSUS
FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11494
State File No. _____
Registrar's No. 3514

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 St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lutheran Conv Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Years II Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Marie Schening
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm. F. Schening
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased July 8 1895
(Month) (Day) (Year)

8. AGE: Years 51 Months 8 Days 23
If less than one day hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Invalid

11. Industry or business _____
12. Name Edward C. Reid 4
13. Birthplace Scotland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Decker
15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. F. Schening
(b) Address 5048 Louisiana
17. (a) Burial (b) Date thereof 4-3-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Paul Church Yard

18. (a) Signature of funeral director Schumacher Und Co.
(b) Address 3013 Meramec st.
19. (a) APR 2 1947 (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 8001
(c) City or town St. Louis 1517
(If outside city or town limits, write "RURAL")
(d) Street No. 5048 Louisiana 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 31
year 1947 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from March 27
1947 to March 31 1947
that I last saw him alive on March 30 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia
Due to: Arterio Sclerosis ?
Hemiplegia 5mo
Other conditions: _____
(Include pregnancy within 3 months of death)
Major findings: 83
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, or farm, in industrial place, in public place?
23. Signature: W. J. [Signature] (b) Door or other _____
While at work? _____ (c) Means of injury _____
Address: 4724 Grand Date signed: 4/11/47

