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DEPARTMENT OF HEALTH
 BUREAU OF THE CENSUS
 FILED SEP 23 1947

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

State File No. _____
 Registrar's No. 8619

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 St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: MISSOURI BAPTIST HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

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

4. Sex F 5. Color or race White
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: 9-9-47
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>2</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name: August Ernest Schreiber
 13. Birthplace: Restus, Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name: Margaret Mary Miller
 15. Birthplace: St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: Mother
 (b) Address: 2505 University Street

17. (a) Burial (b) Date thereof: 9-13-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: Lake Charles town.

18. (a) Signature of funeral director: Geo. L. Pleitsch, Inc.
 (b) Address: 5966-68 Easton Avenue

19. (a) SEP 12 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. 2505 University Street
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19th
 year 1947 hour _____ minute 45 A. M.
 21. I hereby certify that I attended the deceased from Sept 9
 _____, 1947, to Sept 11, 1947
 that I last saw her alive on Sept 11, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity.
 Due to _____
 Due to _____
 Other conditions: _____
(Include pregnancy within 3 months of death)

Duration

Major findings:
 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, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature: E. H. Kuster (M. D. or other) _____
 Address: 3121 Grand Date signed: 9/12/47

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.

Not Embalmed
Pro. Heisch.
#837

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.