

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9912**

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:
1419 Hickory Lane
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **5 1/2** years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **ANNA SCHAAL**
3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Charles** 6. (c) Age of husband or wife if alive **77** years

7. Birth date of deceased **February 12, 1864**
(Month) (Day) (Year)

8. AGE: Years **83** Months **8** Days **14** If less than one day _____ hr. _____ min.

9. Birthplace **Shandon, Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant **Raymond Schaal**

(b) Address **1419 Hickory Lane**

17. (a) **burial** (b) Date thereof **10-28-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Hope Cemetery**

18. (a) Signature of funeral director **A.W. McLaughlin**

(b) Address **2301 Lafayette Avenue**

19. (a) **OCT 27 1947** (b) **J. F. Brusek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **ST. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **1419 Hickory Lane** **9**
(If rural, give location) **22**
(e) Citizen of foreign country? **no** (Yes or No) **1**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **26th**
year **1947** hour **7:15** minute **a.** M.

21. I hereby certify that I attended the deceased from **10:30-46**
_____ 19____ to **10-26** 19____
that I last saw her alive on **10-25** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Valvular Disease (Chronic Cardiac)**

Due to _____

Due to **Hb**

Other conditions **Co of Stomach**
(Include pregnancy within 3 months of death)

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?

While at work? _____ (Specify type of place)
(e) Means of injury **no**

23. Signature **A. Bouhaem** (M. D. or other) _____
Address **2021 Park Ave** Date signed **10-27-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

Dr. A. Bouhasin
2355 Lafayette Ave

5. 5

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. R. Casper*

Licensed Embalmer No. *3633*

P. O. Address. *2317 Lafayette*

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.