No. 2
12-45
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 31 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 43470

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11491

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: LITTLE SISTERS POOR (SOUTH SIDE)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3400 S Grand 2 YRS. 5 (Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Oak

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. LITTLE SISTERS POOR (SOUTH GRAND
(If rural, give location)
3400 S Grand 9

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME FRANK SCHNORBUS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWER

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased JANUARY 17, 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 28 If less than one day hr. min.

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

10. Usual occupation WIDOWER

11. Industry or business

FATHER
12. Name HENRY SCHNORBUS
13. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name BERNADINE RICHTER
15. Birthplace WISCONSIN
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. BERNADINE LAMPRECHT

(b) Address 4825 AUTUMN DR.

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

(c) Place: burial or cremation S.S. PETER + PAUL CEM.

18. (a) Signature of funeral director Thomas Kuti & Son

(b) Address 2906 GRAVOIS

19. (a) DEC 16 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 15
year 1947 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov 8 1945 to Dec 15 1947, to 12/15 1947, that I last saw h alive on Dec 9 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage — Duration 1 Week

Due to Arteriosclerosis — 2 yrs

Due to

Other conditions
(Include pregnancy within 3 months of death)

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature E. R. Bredeck (M. D. or other)

Address 607 N Grand Date signed 12/16/47

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 4347

P. O. Address 2906 Francis

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.