

FILED AUG 28 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28196

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7324**

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 Barnes Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 14 days  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME August B. Schowengerdt

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Matilda E. 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased August 6 1879  
 (Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days 14  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Berger Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Minister

11. Industry or business \_\_\_\_\_

12. Name Martin E. Schowengerdt

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

14. Maiden name Rose Carl

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

16. (a) Informant Mrs. Matilda Schowengerdt

(b) Address Belle, Missouri

17. (a) Burial (b) Date thereof 8-22-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Ave.

19. (a) 8-20-48 (b) J. J. Budich  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries  
 (c) City or town Belle  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. N.R. (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20  
 year 1948 hour 5 minute 07 AM.

21. I hereby certify that I attended the deceased from August 6  
1948, to August 20, 1948  
 that I last saw him alive on August 20, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Post operative shock Duration 2 days

Due to ADENOMA OF PITUITARY

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? \_\_\_\_\_ (c) Means of injury 9

23. Signature JR Bradley (M. D. or other) \_\_\_\_\_  
 Address Barnes Hospital Date signed 8/20/48

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

0-2  
-45  
-39  
47070

**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.....

*Jay W. Wilkinson*

Licensed Embalmer No.....

*3575*

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.**