

FILED DEC 14 1948 **318**
Registration District No.

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: DePaul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Josephine Schroeder

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased July 14 1938
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>10</u>	<u>4</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Student

11. Industry or business _____

12. Name Joseph C. Schroeder

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

14. Maiden name Euna Nevins

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

16. (a) Informant Joseph C. Schroeder

(b) Address 509 Weigle Ave.

17. (a) Burial (b) Date thereof 12-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cuba, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) DEC 2 1948 (b) J. B. Pauster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Ferguson
(If outside city or town limits, write "RURAL")

(d) Street No. 509 Weigle
NR (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1
year 1948 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from 11-6-48
to 12-1-48

that I last saw her alive on 12-1-48
and that death occurred on the date and hour stated above.

Immediate cause of death acute lymphatic leukemia

Due to _____

Due to _____

Other conditions: (Include pregnancy within 3 months of death) MI

Duration

2+ weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

23. Signature Albert H. Hoppe (M. D. or other) _____

Address 3250 Washington Date signed _____

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 ME

....., Registered Apprenticè No.
working under my personal supervision.

Signed Guy 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.