

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6663
1956
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY OR TOWN ST LOUIS		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL		d. STREET ADDRESS (If rural, give location) 3619 LAFAYETTE AVE	

3. NAME OF DECEASED (Type or Print) a. (First) MARTHA b. (Middle) c. (Last) SCHROEDER			4. DATE OF DEATH (Month) (Day) (Year) FEB. 26, 1949		
5. SEX FEMALE		6. COLOR OR RACE WHITE		8. DATE OF BIRTH MAY 22, 1889	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED MARRIED		9. AGE (In years last birthday) 59		10. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) ST LOUIS, Mo.	

13a. FATHER'S NAME JOHN LANKENAU		13b. MOTHER'S MAIDEN NAME JOHANNA PAULS		14. NAME OF HUSBAND OR WIFE ADOLPH P. SCHROEDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS ROBERT C. MAUER 5421 WABADA AVE	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism - 5 hr. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Lung - 7 months - 47 DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION May 1948		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Lung - 16 X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2-4, 1947 to 2-26, 1949, that I last saw the deceased alive on 2-26, 1949 and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. F. Blas M.D.		23b. ADDRESS 3720 Washington		23c. DATE SIGNED 3-1-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MARCH 2, 1949		24c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY	
DATE REC'D BY LOCAL REG. MAR 1 1949		REGISTRAR'S SIGNATURE J. B. Luster		24d. LOCATION (City, town, or county) (State) ST. LOUIS, Mo.	
25. FUNERAL DIRECTOR'S SIGNATURE Wm J. Robert & H. Co.		ADDRESS 1905 So. GRAND Bldg			

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING.** (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.