

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27958  
Registrar's No. 7690

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		State File No. <u>27958</u>		Registrar's No. <u>7690</u>					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) township) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lemay</u>		0 1/2							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital (U)</u>				d. STREET ADDRESS (If rural, give location) <u>W.R. 9523 Longwood ave.</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u>			b. (Middle) _____			c. (Last) <u>Dannecker</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>September 2, 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 18, 1886</u>		9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News Vendor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Globe-Democrat</u>		11. BIRTHPLACE (State or foreign) country) <u>Indiana</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Myrtle Dannecker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Myrtle Dannecker 9523 Longwood</u>							
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) _____  ANTECEDENT CAUSES DUE TO (b) <u>Lobar Pneumonia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Chronic Myocarditis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  INTERVAL BETWEEN ONSET AND DEATH _____											
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>108</u>		495X							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 <u>1945</u> , to _____, 19____, that I last saw the deceased alive on <u>6, 19</u> and that death occurred at <u>11 p.m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE <u>[Signature]</u> (Degree or title)				23b. ADDRESS <u>1300 Clark Ave</u>				23c. DATE SIGNED _____					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 6, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST Trinity Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Lemay Mo</u>							
DATE RECEIVED BY LOCAL HEALTH DEPT. <u>SEP 6 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. Hoffmeister U. &amp; L. Co. 7814 S. Broadway</u>									

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.

Signed Harry J. Schumacher

Licensed Embalmer No. 2679

Signed \_\_\_\_\_  
Student Embalmer

P. O. Address 7814 T. Broadway

**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.