

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6712

State File No. ....

1652

318

1003

|   |  |   |  |  |  |  |   |  |
|---|--|---|--|--|--|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. _____  |  | PRIMARY REG. DIST. NO. _____   |  | Registrar's No. _____  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY _____ |  |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>   |  | c. LENGTH OF STAY (In this place) _____   |  | c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>  |  | d. STREET ADDRESS <b>4639 Pope Ave</b>                                   |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4639 Pope Ave</b>  |  |   |  | d. STREET ADDRESS <b>4639 Pope Ave</b>   |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>William</b> b. (Middle) <b>F.</b> c. (Last) <b>Schroeder</b>   |  |   | 4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 18, 1950</b> |  |  |  |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  |  | 8. DATE OF BIRTH <b>May 30, 1902</b>                                     |   |  |
| 9. AGE (In years last birthday) <b>47</b>   |  |   |  | 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) <b>Order Clerk</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY _____                    |  | 11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>                           |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME <b>Charles Schroeder</b>   |  |   | 13b. MOTHER'S MAIDEN NAME <b>Catherine Rose</b>            |  |  | 14. NAME OF HUSBAND OR WIFE <b>Clara Schroeder</b>                       |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>489-01-2306</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Clara Schroeder 4639 Pope Ave</b>  |  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Calcification aorta</b><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b>                                    |  |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____  |  |  |  |  | 20. AUTOPSY?<br>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) <b>Mo</b>  |  | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____             |   |  |
| 21d. TIME OF INJURY _____   |  | 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 <b>June 49</b> , 19 <b>50</b> , to <b>2-18</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>2-17</b> , 19 <b>50</b> , and that death occurred at <b>12:30P.m.</b> , from the causes and on the date stated above. |  |   |  |  |  |  |   |  |
| 23a. SIGNATURE <b>[Signature]</b> (Degree or title) _____   |  |   |  | 23b. ADDRESS <b>2149 1/2 Maryland</b>  |  | 23c. DATE SIGNED <b>2-20-50</b>  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24b. DATE <b>2-21-50</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b> |   |  |
| DATE REC'D BY LOCAL REG. <b>FEB 20 1950</b>   |  | REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Math. Hermann &amp; Son, Inc. 2161 E. Fair Ave</b> |  |   |  |

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

male

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed Glenn W. Hay

Licensed Embalmer No. 3737

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.