

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **35146**  
**8792**

FILED OCT 24 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis Mo.</b>		c. CITY OR TOWN <b>St. Louis Mo.</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY in this place <b>17</b>		e. STREET ADDRESS (If rural, give location) <b>5 5944 Cabanne Place</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5944 Cabanne Place</b>			

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Mathilda</b> b. (Middle) <b>NMN</b> c. (Last) <b>Schroer</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Oct. 7, 1955</b>		
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Nov. 1, 1871</b>	<b>9. AGE</b> (In years last birthday) <b>83</b>	<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>St. Louis Missouri</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					

<b>13a. FATHER'S NAME</b> <b>Martin J. Steinicke</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Frederick W. Schroer</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs. Irving Smith</b> <b>ADDRESS</b> <b>5944 Cabanne Place.</b>	

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)		<b>MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac failure</b>		DUE TO (b) <b>Hypertensive Cardio-vascular renal Arteriosclerosis.</b>			<b>1 year</b>
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <b>Left hemiplegia</b>			<b>11 years +</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes mellitus</b> <b>Sarcoma right breast</b>		<b>442 X H</b>			<b>11-9-48 since 1895</b>

<b>19a. DATE OF OPERATION</b> <b>5-1-45</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Radical mastectomy Sarcoma. No recurrence</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) <b>No</b>		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ m.		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	

**22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1938, to October 7, 1955, that I last saw the deceased alive on 9-8-55, 19\_\_\_\_, and that death occurred at 11:30A m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>[Signature]</i>		<b>23b. ADDRESS</b> <b>864 Hamilton Blvd. St. Louis 12 Missouri</b>		<b>23c. DATE SIGNED</b> <b>10-8-55</b>	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>24b. DATE</b> <b>Oct. 10, 1955</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Hill Cemetery</b>	
		<b>24d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County Missouri.</b>			

<b>DATE REC'D BY LOCAL REG.</b> <b>OCT 10 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C.R. Lupton and Sons</b> <b>ADDRESS</b> <b>7233 Delmar Blvd.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed..... *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.