

FILED NOV 6 1948 318
Registration District No. _____

Primary Registration District No. _____

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:
4432 DEWEY AV. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 4432 DEWEY AV. 1
(If rural, give location)

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

3. (a) PRINT FULL NAME EMMA E. SCHOEN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26
year 1948 hour 6 minute 30 p.m.

21. I hereby certify that I attended the deceased from
Sept. 18, 1948, to October 26, 1948;
that I last saw her alive on October 26, 1948;
and that death occurred on the date and hour stated above.

4. Sex FE. 1

5. Color or race W.

6. (a) Single, widowed, married, divorced W. 3

6. (b) Name of husband or wife JOHN S. SCHOEN

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

7. Birth date of deceased FEB. 16 1873
(Month) (Day) (Year)

Immediate cause of death Hypertensive heart disease Duration 9/18/48+

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years 75 Months 8 Days 10
If less than one day _____ hr. _____ min.

9. Birthplace HIGHLAND ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER OWN.

11. Industry or business _____

12. Name CARL HAENNI 3

13. Birthplace SWITZERLAND
(City, town, or county) (State or foreign country)

14. Maiden name JACKABENA UNK. 1

15. Birthplace GERMANY 7
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr Carl Schoen 1.

(b) Address 859 Providence

17. (a) BURIAL (b) Date thereof Oct 29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. Olive All.

18. (a) Signature of funeral director E. J. Schmur

(b) Address 3125 Lafayette Ave.

19. (a) OCT 27 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 Barned T. [Signature] (M. D. or other) _____
Address 4755 Morgan Rd Date signed 10/27/48

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

MOTHER FATHER

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.....

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

Signed John B. Volmer.....

Licensed Embalmer No. 4014.....

P. O. Address 3125 Lafayette Ave. 4......

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.