9770

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

34259

State File No. 8797

791

Registration District No. 1003   Primary Registration District No.   Registrar's No.

REC'D NOV 13 1939

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St Louis 18
(If outside city or town limits, write "RURAL")
(d) Street No. 4340 Vista Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Katie Scheer 603

3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Late Peter Scheer
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 5 1874
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 10 If less than one day hr. min.

9. Birthplace Hungary
(City, town, or county) (State or foreign country)
10. Usual occupation Housework
11. Industry or business At Home

FATHER
12. Name Unknown Veszlek
13. Birthplace Hungary
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Hungary
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Peter Scheer
(b) Address 4340 Vista ave
17. (a) Cremation (b) Date thereof 10-17-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mo. Crematory
18. (a) Signature of funeral director Kriegshauser Mortuaries
(b) Address 4228 S. Kingshighway
19. (a) OCT 16 1939 (b) J. B. Bradbeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15,
year 1939 hour 3:45 minute A. M.

21. I hereby certify that I attended the deceased from October 11, 1939 to October 15, 1939
that I last saw her alive on October 15, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis, chronic — Duration

Due to Post operative complications

Due to

Other conditions Cirrhosis of Liver
(Include pregnancy within 3 months of death)

Major findings:
Of operations Ovarian cyst non Malignant
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature M. A. Casberg (M. D. or other)
Address 1515 Lafayette. 10/16/39 Date signed

(Licensed Embalmer's Statement on Reverse Side)

I X19511

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 Reinhold K. Lohmann

Licensed Embalmer No. 3395

P. O. Address.....

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, above space should be left blank.