

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.

REC'D AUG 17 1939

791  
1008

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3710a S. Jefferson ✓  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 57 years years, months or days)

3. (a) PRINT FULL NAME John Schumann 55D

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Catherine 6. (c) Age of husband or wife If alive --- years

7. Birth date of deceased August 23, 1865  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>10</u>	<u>13</u>	hr. _____ min.

9. Birthplace Germany 6  
(City, town, or county) (State or foreign country)

10. Usual occupation Gents Furnishings 4

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown 9

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant's own signature Florence Schumann

(b) Address 3710a S. Jefferson

17. (a) Burial (b) Date thereof 7/8/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn

18. (a) Signature of funeral director Wacker-Weldert

(b) Address 2331 S. Broadway

19. (a) JUL 6 1939 (b) J. B. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 24  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3710a S. Jefferson  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5  
year 1939 hour 1 minute 20 p. m.

21. I hereby certify that I attended the deceased from July 21,  
1937, to July 6, 1939;  
that I last saw him alive on July 6, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis  
Chronic Interstitial Nephritis  
Atrophic Corrosion of Stomach  
(not alcoholic)  
Duration May, 1937  
July, 1937  
July, 1938

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Arterial Sclerosis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy no

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) no  
(b) Date of occurrence no  
(c) Where did injury occur? no  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place)  
(a) Means of injury \_\_\_\_\_

23. Signature Henry B. Turner (M. D. or other)  
Address 508 N. Grand Blvd Date signed \_\_\_\_\_

**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.....

*Robert C. Wheeler*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Robert C. Wheeler*

Licensed Embalmer No. *2178*

P. O. Address *W. H. Anderson*

**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.**