DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27919

Registration District No. 791 1003 — Primary Registration District No. — Registrar's No. 7419

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3438a Keokuk St.,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Lifetime (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3834a Keokuk St.,
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Jacob Schott 300
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife KATE
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased 9 (Month) 16 (Day) 1873 (Year)

8. AGE: Years 65 Months 11 Days 12 If less than one day hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Grocer, own business
11. Industry or business Grocer store.
FATHER
12. Name Lawrence Schott
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Elizabeth Rapp
15. Birthplace Germany (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs Kate Schott
(b) Address 3834a Keokuk St. St. Louis Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (Month) 31 (Day) 39 (Year)
(c) Place: burial or cremation Valhalla Cemetery
18. (a) Signature of funeral director Wacker Helderle Co LC
(b) Address 2331 S. Broadway
19. (a) AUG 29 1939 (Date received local registrar) (b) J. F. Bashuk (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28th year 1939 hour One minute 25 P. M.
21. I hereby certify that I attended the deceased from March 7 1934, 19, to Aug 28th, 1939; that I last saw him alive on Aug 28th, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Interstitial Nephritis from March 7th 1934 to Aug 28. 1939	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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 A. A. Gebhardt (M. D. or other)
Address 3438 Chiffwa Date signed 8/29/39

(Licensed Embalmer's Statement on Reverse Side)

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.

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 Robert C. Wheeler, Registered Apprentice No. ..... working under my personal supervision.

Signed Robert C. Wheeler

Licensed Embalmer No. 2178

P. O. Address [illegible]

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.