

Registration District No.

Primary Registration District No.

Registrar's No.

8528

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis
(c) Name of hospital or institution: 3423a Giles
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME George Adams Schuetz8. (b) If veteran, name war No 8. (c) Social Security No. No4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Ida Schuetz 6. (c) Age of husband or wife if alive 78 years7. Birth date of deceased May 16 1859
(Month) (Day) (Year)8. AGE: Years 80 Months 4 Days 27 If less than one day hr. min.9. Birthplace Waterloo Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Street RR Employee11. Industry or business Street RR12. Name Valintene Schuetz13. Birthplace Germany
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Shirley M. ...(b) Address 3423 a Giles17. (a) Burial (b) Date thereof 10-6-39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Matthews Cem18. (a) Signature of funeral director A.W. McLaughlin(b) Address 2301 Lafayette19. (a) OCT 5 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")
(d) Street No. 3423a Giles
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3
year 1939 hour 2 minute 40 P. M.21. I hereby certify that I attended the deceased from Aug 27, 1939, to Oct 31, 1939.

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

PneumoniaDue to Strangulated Hernia

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

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 Shirley M. ... (M. D. or other) _____Address 3702 Grand 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.....

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

Signed

L. R. Cooper

Licensed Embalmer No. *3633*

P. O. Address *23170 Lafayette*

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.