

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.

REGISTRATION DISTRICT NO. 1008

PRIMARY REGISTRATION DISTRICT NO. _____

REGISTRAR'S NO. 9399

1. PLACE OF DEATH:

(a) County 1
(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 and location)
(d) Length of stay: In hospital or institution 17 Days
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 8
(If outside city or town limits, write "RURAL")
(d) Street No. 431 Antelope St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Schulte 430

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

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

6. (b) Name of husband or wife George Schulte 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased About 55 1884
(Month) (Day) (Year)

8. AGE: Years 55 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER { 12. Name John West

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature George Schulte

(b) Address 431 Antelope St.

17. (a) Burial (b) Date thereof 11/4/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N. St. Marcus

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

(b) Address 2331 S. Broadway

19. (a) NOV 2 1939 (b) J. F. Gudsch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 1,
year 1939 hour 5:30 minute P. M.

21. I hereby certify that I attended the deceased from October
16, 1939 to November 1, 1939
that I last saw her alive on November 1, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of ovary
& metastasis Duration _____

Due to _____
Due to _____

Other conditions MI
(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? _____

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

23. Signature John F. Flynn (M. D. or other)
Address 1515 Lafayette 11/2/39
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 Robert Ciuchelli
Licensed Embalmer No. 3178
P. O. Address St. Louis, Mo.

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.