

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.

DEC 12 1939
Registration District No. 84

Primary Registration District No. 200

State File No. _____

Registrar's No. 2001

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Bonhomme Township Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bonhomme Regst Home B-895 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

8. (a) PRINT FULL NAME Frederick W. F. Schutze 3011

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 24 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
69	2	21	hr. _____ min. _____

9. Birthplace England 4
(City, town, or county) (State or foreign country)

10. Usual occupation Collector 6

11. Industry or business Retired 4

12. Name Frank G. Schutze

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

14. Maiden name Mary Ann Guest
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Frank E. Schutze

(b) Address 1921a McCausland Ave

17. (a) Burial (b) Date thereof 11-18-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Archibald H. Harris

(b) Address 1905 Union Blvd.

19. (a) NOV 16 1939 (b) E. R. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. 1 (b) County St. Louis

(c) City or town BSt. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1921a McCausland
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15
year 1939 hour 9 minute 55 a. m.

21. I hereby certify that I attended the deceased from Jan 20, 1939, to Nov 15, 1939;
that I last saw him alive on Nov 15, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease Duration 2 yrs

Due to _____

Due to _____

Other conditions Pneumonia 3 days
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy none

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 _____

28. Signature Paul D. Hageman (M. D. or other) _____

Address 3720 Washington Date signed 11/16/39

*Barroness Rd
4-6 steps Saturday*

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 Warren A Carver

Licensed Embalmer No. 3534

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.