

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. 791

Primary Registration District No. 1006

Registrar's No. 4045

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:  
4650 So. Grand  
(If not in hospital or institution, write street number or location)

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

In this community Life  
years, months or days

3. (a) PRINT FULL NAME Emma Schumacher 526

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 Widow

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Sept 1st, 1859  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>8</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation At home

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

MOTHER FATHER

12. Name Benedict Schulz

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

14. Maiden name Caroline Schmidt  
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Benedict Schulz

(b) Address 4650 So. Grand

17. (a) Burial (b) Date thereof 5/7/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director John Ziegenhagen & Sons

(b) Address 7627 Gravois Ave.

19. (a) MAY 6 1940 (b) \_\_\_\_\_  
(Date received local registrar) (City, town, or county)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis 15  
(If outside city or town limits, write "RURAL")

(d) Street No. 4650 Sol Grand  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th  
year 1940 hour 10:00 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Sept 29  
1940 to May 4 1940  
that I last saw her alive on May 4 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Arteriosclerosis

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

Other conditions As C  
(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 E. E. Moeller (M. D. or other) \_\_\_\_\_  
Address 3537 S. Jefferson Date May 4/40

**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..... *E. P. Kidwell* .....

Licensed Embalmer No. *3877* .....

P. O. Address. *6937<sup>a</sup> Kraussis* .....

**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.**