

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis,  
(b) City or town St. Louis,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Deaconess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 Days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis, 20  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2535 University St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Martha Schuetz, 320

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 Alfred 6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased Sept. 21st, 1906  
(Month) (Day) (Year)

8. AGE: Years 33 Months 10 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace New Haven, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Wm. F. Schroeder

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

MOTHER FATHER { 14. Maiden name Sophia Altemeyer,

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

16. (a) Informant Mr. Alfred Schuetz,

(b) Address 2535 University Street.

17. (a) Burial (b) Date thereof 7-26-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Port Hudson, Mo.

18. (a) Signature of funeral director My Reichner Mch. Co

(b) Address 2223 St. Louis Ave.,

19. (a) \_\_\_\_\_ (b) J. F. Bredenk  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1940 hour 1 minute 55 P.M.

21. I hereby certify that I attended the deceased from Dec. 29  
1939 to July 23, 1940:  
that I last saw her alive on July 23, 1940:  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinosis metastatic  
GENERAL CAUSE OF DEATH \_\_\_\_\_

Due to Carcinoma left mammary gland 1 yr.

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

Other conditions (Include pregnancy within 3 months of death) 50

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Arthur Scindler (M. D. or other) h.w.d

Address 2202 University St. Date signed July 24

Duration 6 mo.  
1 yr.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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

*John P. Burchhart*

Licensed Embalmer No. *1674*

P. O. Address *2223 St. Louis Ave*

**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.**