

1940
Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **2169**

1. PLACE OF DEATH: **ST. Louis**
(a) County **St. Louis**
(b) City or town **Carondelet, LEMAY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Robert Koch Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **36 days**
(Specify whether years, months or days) **1**

3. (a) PRINT FULL NAME **Adolph Schuster**
3. (b) If veteran, name war _____
3. (c) Social Security No. **413-10-7348**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **divorced**
6. (c) Age of husband or wife if **24**
7. Birth date of deceased **August 24 1903**
(Month) (Day) (Year)

8. AGE: Years **37** Months **2** Days **21**
If less than one day hr. _____ min. _____

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

10. Usual occupation **Tool Worker** **0**

11. Industry or business _____

12. Name **Edward Schuster** **6**

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

14. Maiden name **MARTHA Schreve**

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

16. (a) Informant **Michael Mc Govern**
(b) Address **7474 Newhouse**

17. (a) **BURIAL** (b) Date thereof **Nov. 16-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director **MT. HOPE CEM.**
(b) Address **7814 S. Broadway**
19. (a) **NOV 17 1940** (b) **W. H. Meyer, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **ST. Louis**
(c) City or town **ST. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1414 Newhouse**
(If rural, give location) **0**
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **14**
year **1940** hour **4** minute **13** A.M.

21. I hereby certify that I attended the deceased from **10-9-40**
19____, to **11-14-40**, 19____;
that I last saw him alive on **11-13-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**

Due to _____

Due to **2/3**

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

Major findings: _____
Of operations _____

Of autopsy **Pulmonary Tuberculosis
T.B.C. lungs, intestines.**

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? **NO**
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **Ben Berman** (M. D. or other) **1**
Address **Koch Hospital** Date signed **11-14-40**

Duration **3 yrs.**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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

Linus C. Hoffmeister

Licensed Embalmer No.

3871

P. O. Address

7814 S. Broad

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.