

EC APR 15 1943 784

State File No. \_\_\_\_\_  
Registrar's No. 784

Registration District No. \_\_\_\_\_ Primary Registration District No. 200

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Koch  
(c) Name of hospital or institution: Robt. Koch Hospital  
(d) Length of stay: In hospital or institution 9 1/2 mos.  
In this community 1 yr

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(d) Street No. 1411 N. Sarah  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Schuler, Samuel  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 429-05-6670

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 31st  
year 1943 hour 8 minute 45 A.M.

4. Sex male 5. Color or race negro  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Ellerjewel Schuler  
6. (c) Age of husband or wife if alive ? years  
7. Birth date of deceased Sept. 5, 1908

21. I hereby certify that I attended the deceased from 6/2/42 to 3/31/43  
that I last saw him alive on 3/31/43  
and that death occurred on the date and hour stated above.

8. AGE: Years 34 Months 6 Days 26 hr. \_\_\_\_\_ min.

Immediate cause of death pulmonary tuberculosis  
Duration 13 mos.

9. Birthplace Warren, Arkansas

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation laborer

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

11. Industry or business steel

12. Name Joe Schuler

13. Birthplace North Carolina

14. Maiden name Fiona Thomas

15. Birthplace South Carolina

16. (a) Informant pt. on entry to hospital

17. (a) (b) Date thereof 4-5-43

(c) Place: burial or cremation Warren Ark

18. (a) Signature of funeral director A. F. Walton

(b) Address 2707 Stoddard St

19. (a) APR 3 1943 (b) E. G. W. ...

Of autopsy none done  
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Koch Hospital, Robt. Koch Date signed 4/1/43

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.....

Licensed Embalmer No.....

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, fact should be so stated above.**