

V. S. No. 2
FORM-2-43
Revised 5-17-39

30366

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED OCT 13 1943

318 STANDARD CERTIFICATE OF DEATH

State File No.

1003

Registrar's No.

8634

Registration District No.

Primary Registration District No.

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:
in route city Hosp # 1
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 3
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town St. Louis 319
(If outside city or town limits, write "RURAL")
(d) Street No. 6958 Hancock
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Joseph Schuler

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased abt
(Month) (Day) (Year)

1884
(Month) (Day) (Year)

8. AGE:

Years Months Days If less than one day

abt 59

9. Birthplace

(City, town, or county) 4 Cuba
(State or foreign country)

10. Usual occupation

Cook

11. Industry or business

MOTHER FATHER

12. Name William

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

14. Maiden name William

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

16. (a) Informant James J. Pizzommi

(b) Address 1300 Clark St

17. (a) (Burial, cremation, or removal) Washington

(b) Date thereof 9, 8, 43
(Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. ...

(b) Address 3500 ...

19. (a) SER 30 1943

(b) (Registrar's signature) J. F. ...

(Date received local registrar) 1943

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23
year 1943 hour 7 minute 30 P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery and Colitis with Chronic Myocarditis

Due to no diet
Due to Cataracts

Other conditions (include pregnancy within 3 months of death) 93

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)
(c) Means of injury _____

23. Signature W. R. ... (M. D. or other)
Address ... Date signed 9/7/43

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

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

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.