S. No. 2
DM—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33529

OCT 27 1943

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 0227

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Margaret Schultz

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 Joseph Schultz

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Aug. 30, 1882 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
61	1	19	hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Daven
13. Birthplace Ohio (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Margaret Ryan
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Joseph Schultz
(b) Address Chesterfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bromschwig Und. Co.
(b) Address 4746 West Florissant Ave.

19. (a) OCT 20 1943 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19 year 43 hour — minute 2 P.M.

21. I hereby certify that I attended the deceased from Oct 3, 1943 to Oct 19, 1943 that I last saw her alive on Oct 19, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic degenerative heart disease — Duration years

Due to

Due to Cardiac decompensation — 2 months

Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address 539 N Grand Date 10/19/43

(Licensed Embalmer's Statement on Reverse Side)

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. G W Wilkinson

Licensed Embalmer No. 3575

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.