

FILED APR 15 1944

Registration District No. 3

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Manchester Nursing Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 years  
(Specify whether  
In this community Unknown  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 96  
(c) City or town Manchester 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. St. Louis County  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Julia Schulz

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William F. Schulz 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 24 1862  
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Home

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Schulz  
(b) Address 2349a So 10 th. St.

17. (a) Cremation (b) Date thereof 11/11/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Walter A. Aldred, D.D., Co.

(b) Address 3634 Gravois Ave.

19. APR 12 1944 (b) E. D. McDevan  
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8 th. 1944  
year 1944 hour 10:00 minute A.M.

21. I hereby certify that I attended the deceased from Dec 1 1943 to April 8 1944

that I last saw her alive on April 6 1944 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis Duration \_\_\_\_\_

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

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. J. Nefflin M.D. (M.D. or other) \_\_\_\_\_

Address 3507 P. Lamar Date signed 4-10-44

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

680

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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

*Frank J. Chas.*

Licensed Embalmer No.

*9645*

P. O. Address

*St. Louis Mo*

**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.**