

S. No. 2
M-5-43
7-5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12185**
Registrar's No. **766**

Registration District No. **317**

Primary Registration District No. **3063**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital **0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month 1 day
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis **96**
(c) City or town Overland **13**
(If outside city or town limits, write "RURAL") **7**
(d) Street No. 8283 Albin
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Albert Schurter
3. (b) If veteran, name war --
3. (c) Social Security No. --

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 12
year 1944 hour 12:10 minute P. M.
21. I hereby certify that I attended the deceased from
2-12-44, 19 to 3-12-44, 19 ;
that I last saw him alive on 3-12-44, 19 ;
and that death occurred on the date and hour stated above.

4. Sex Male **0** 5. Color or race White **0**
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 14, 1873
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Prostate
Duration unknown
Due to _____
Due to _____

8. AGE: Years Months Days If less than one day
70 5 27 hr. min.

Other conditions Cystitis, Arteriosclerosis, Leuk, Inguinal Heemia,
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy nil
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace Detroit Mich.
(City, town, or county) (State or foreign country)
10. Usual occupation Odd Jobs

11. Industry or business _____
12. Name Unknown
13. Birthplace Unknown Canada **2**
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Canada **2**
(City, town, or county) (State or foreign country)

16. (a) Informant Mary W. Hansman
(b) Address St. Louis County Hospital
17. (a) Removal (b) Date thereof 3-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis County Hospital
18. (a) Signature of funeral director W. Richter
(b) Address 3500 Rutledge
19. (a) MAR 30 1944 (b) E. J. Mc Lavran
(Date received local registrar) (Registrar's signature)

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) _____
(e) Means of injury _____
23. Signature John Niederwimmer (M. D. or other) M.D.
Address St. Louis County Hosp. Clayton Date signed 3-15-44

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.