

FILED NOV 10 1944

Registration District No.

Primary Registration District No.

Registrar's No.

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
 (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:  
En Route To City Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community Life.  
years, months or days)

3. (a) PRINT ROBERT SCHOTTEL  
 FULL NAME

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 Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased: April 22 1931  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>13</u>	<u>6</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation At School

11. Industry or business Student.

MOTHER FATHER { 12. Name John Schottel  
 13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Lillian Sinks  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant John Schottel  
 (b) Address 3209 S 9th St.

17. (a) Burial (b) Date thereof 11-2-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter & Paul

18. (a) Signature of funeral director Thornton & Son  
 (b) Address 2906 Gravois Ave.

19. (a) OCT 30 1944 (b) J. F. Brauer  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St Louis.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3209 S 9th St.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29  
 year 1944 hour 11 15 minutes A.M. 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 Edema of stomach  
abscess of throat  
 Due to \_\_\_\_\_  
 Due to 1/5 c 2  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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?  
(Specify type of place)

White at work? \_\_\_\_\_  
 Means of injury \_\_\_\_\_  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address [Signature] Date signed 10/30/44

**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 *David Lee Fossas*.....

Licensed Embalmer No. *4242*.....

P. O. Address. *2906 Harris*.....

**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.**