

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

FEDERAL BUREAU OF INVESTIGATION
 National Office of Vital Statistics
 FILED NOV 12 1948 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34680**
 Registrar's No. **9455**

Registration District No. **318**
 Primary Registration District No. **1003**

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: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME MATILDA SCHUMANN

3. (b) If veteran, name war NONE

3. (c) Social Security No. _____

4. Sex F | 5. Color or race W

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 Sept 21 1896
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>1</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation mil

11. Industry or business _____

MOTHER FATHER

12. Name August Schumann

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

14. Maiden name MARY Dippel

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

16. (a) Informant Fred Schumann

(b) Address 4560 Shenandoah

17. (a) BURIAL (b) Date thereof Nov. 1, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Pickers Cem.

18. (a) Signature of funeral director Witt Bers & Co.

(b) Address 2929 S. Illinois Ave

19. (a) NOV 1 1948 (b) W. J. Lassiter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 5400 Harsenal St. Memorial
(If rural, give location)

(e) Citizen of foreign country? 13 (Yes or No) _____
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31st
 year 1948 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from 9/30/48
 _____, 19____, to Oct. 31st, 1948

that I last saw her alive on Oct. 31st, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary tuberculosis, moderately advanced
 Duration unknown

Due to _____

Due to _____

Other conditions: psychosis due to arteriosclerosis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

23. Signature Frank J. Martin (M. D. or other) _____
(Specify type & place) (City or town) (County) (State)

Address 1515 Lafayette Date signed 11/1/48

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.....

Not Embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Harold C. Witt

Licensed Embalmer No.

4353

P. O. Address.....

2929 S. Jefferson

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.

2B
3-45
X43880

State File No. Nov
Registrar's No. 9455

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Matilda Schumann

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color of race w 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Sept 21
(Month) (Day) (Year)

8. AGE: Years 72 Months Days (Less than one day) hr. min.

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

10. Usual occupation nie

11. Industry or business

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Data received local registrar) (b) J B Parster (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1946 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from 11 to 11:15 P.M. that I last saw him alive on Nov 17 1946 and that death occurred on the date and hour stated above. Immediate cause of death.....

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..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

NOV 17 1946

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

S-34680

b2 b2 of