

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

10214

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1093**
 City *St. Louis* (No. *City Hospital*)..... St. Ward.....

File No.
 Registered No. **2803**
 St. Ward.....

2. FULL NAME

George J. Schultz
 (a) Residence. No. *1458th Union* St. *6* Ward.....
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* | **4. COLOR OR RACE** *White* | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *(write the word)* *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF (or) WIFE OF *Marie Schultz*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr 2, 1864*

7. AGE
 YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
62 11 18

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Night Watchman*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... *Kentucky*
 (STATE OR COUNTRY)

10. NAME OF FATHER *John Schultz*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... *Kentucky*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Johna Beatty*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... *Kentucky*
 (STATE OR COUNTRY)

14. INFORMANT *Geo J. Schultz*
 (Address) *1468th Union*

15. FILED *22 1927* *Max C. Starosoff*
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 19 1927*

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....
 that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at..... *10:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS: *10:30 A.M.*
Gun shot wounds of
Chest. (duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Suicide* (duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED.....
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF..... *170*

19. WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)..... *Res. J. A. ...*

27 (Address) *Corcoran*
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Valhalla Cemetery* **DATE OF BURIAL** *March 22 1927*

20. UNDERTAKER *Drehmann Sarah* **ADDRESS** *1405 Union*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK.

