

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

Do not use this space.

38465

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

St. Louis Mo. No. 1402 Cass Ave

File No.....

Registered No. **10854**

St.....

Ward.....

2. FULL NAME

George Schottmueller

(a) Residence. No. *1402 Cass Ave* St. *25* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male

White

Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 30 - 1889*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

40

6

4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

Teamster

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....

St. Louis Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER.....

Reinhardt Schottmueller

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....

Germany

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER.....

Helen Wirth

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....

Germany

(STATE OR COUNTRY)

14.

INFORMANT.....

Mrs. P. Sachs

(Address).....

3328 William Pl.

15.

FILED.....

19.....

1428 Paul C. Starker

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov. 7 1929*

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..... *8 - P.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aortic & Mitral Insufficiency

*92A
75D*

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Dilatation of Heart

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?.....

DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

M. D.

11/6 1929 (Address).....

*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

DATE OF BURIAL

Cemetery

Nov. 17 1929

20. UNDERTAKER

ADDRESS.....

H. G. Leidner and Co. N. Market St.

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....
Township..... Primary Registration District No. 1003 Registered No. 10854
City St Louis (No.....) St..... Ward.....

2. FULL NAME

George Schottmuller
(a) Residence. No..... St..... Ward.....
(Usual place of abode) (If nonresident, give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Div.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.

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

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

PARENTS
10. NAME OF FATHER.....
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY).....
12. MAIDEN NAME OF MOTHER.....
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY).....

14. INFORMANT..... (Address).....

15. FILED Jan 30 1924 Max C. Barkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 4 1924

17. Ed. Thomas in attendance
I HEREBY CERTIFY That I attended deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH?..... DATE OF Nov 4
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) John J. Herley M.D.
125 75 (Address) St. Louis

*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 DATE OF BURIAL
19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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. REGISTERS SHALL NOT RECEIVE A. C. FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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