

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

16851
Do not use this space.

1939 JUN 12 1939

4385

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City St. Louis (d) Street No. City Hospital No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
E. 1587

2. PRINT FULL NAME Louis Schumann
 (a) Residence, No. No Home St. MA
 (Usual place of abode, if no street address, write county or city) (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** widowed
 (write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>About 45</u>				

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unknown
9. Industry or business in which work was done, as saw mill, bank, etc. ?
10. Date deceased last worked at this occupation (month and year) **11. Total time (years) spent in this occupation.**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Norfolk, Neb. DATE 5/12/39 19..

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edith E. Ambruster
4234 Manchester

20. FILED MAY 11 1939 J. B. Ruden
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/7/39 19..

22. I HEREBY CERTIFY, That I attended deceased from 5/4/39 19.. to 5/7/39 19..
 I last saw h. him on 5/7/39 19.. Death is said to have occurred on the date stated above, at 7.50 Pm.
 The principal cause of death and related causes of importance were as follows:
Acute Alcoholism
 Date of onset

Other contributory causes of importance:
AD

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) William Sapsun M. D.
 (Address) City Hospital No. 1

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.

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..... *Flora Eymek*
Licensed Embalmer No. *1284*
P. O. Address *St. Louis Mo*

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, above space should be left blank.