

REC'D JUN 12 1939

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

17200

Do not use this space.

791
1008

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No. Registered No. **4734**
(c) City **St. Louis Mo.** (d) Street No. **Lutheran Hospital** 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.

2. PRINT FULL NAME

Margaret Schuler
(a) Residence, No. **2832 Texas Ave.** St. **27**
(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 **Female** 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 **Joseph Schuler**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb 22 1882**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
57 3 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**
9. Industry or business in which work was done, as saw mill, bank, etc. **Housewife.**
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) **Illinois**

FATHER 13. NAME **Joseph Peters**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

MOTHER 15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

17. INFORMANT **Joseph Schuler**
(ADDRESS) **2832 Texas Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Sunset Park** DATE **May 26** 19 **39**

19. FUNERAL DIRECTOR (NAME) **Thos. Kautis**
(ADDRESS) **2906 Gravois Ave.**

20. FILED **MAY 24 1939** **J. B. Brudick**
(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 23, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **March 1, 1938, to May 23, 1939**
I last saw her alive on **May 23, 1939**. Death is said to have occurred on the date stated above, at **2:00 p.m.**
The principal cause of death and related causes of importance were as follows:

Biliary Cirrhosis Date of onset
Other contributory causes of importance: **Myocarditis (chronic)**

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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? **No**
If so, specify
(Signed) **B. J. McGrinnis** M. D.
(Address) **2602 Grand**
St. Louis Mo.

Every item of information furnished on this certificate is required by law to be true and correct. The furnishing of false information is a crime.

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.....

.....
working under my personal supervision.

Leo Budde..... Registered Apprentice No.

Signed..... *Leo Budde*.....

Licensed Embalmer No. *3989*.....

P. O. Address *St. Louis*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 4734

1. PLACE OF DEATH:

(a) County _____
 (b) City or town _____
(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 Margaret Schuller
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex _____
 5. Color or race _____
 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day _____ hrs. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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's own signature _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-1-39 (b) J. J. Predeck
(Date received local registrar) (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) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 23
 Year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

STATE OF MISSOURI, DEPARTMENT OF COMMERCE, BUREAU OF THE CENSUS, MISSOURI STATE BOARD OF HEALTH, STANDARD CERTIFICATE OF DEATH, REGISTRATION DISTRICT NO. _____, PRIMARY REGISTRATION DISTRICT NO. _____, REGISTRAR'S NO. 4734, MARGARET SCHULLER, DATE OF DEATH 5-23-39, REGISTERED 9-1-39, J. J. PREDECK, (LICENSED EMBALMER'S STATEMENT ON REVERSE SIDE)

8.7

S-17200

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.