

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.

STANDARD CERTIFICATE OF DEATH

RECEIVED SEP 14 1939

State File No. 27376

Registrar's No. 6876

Registration District No. 1008 Primary Registration District No. 791

1. PLACE OF DEATH:
 (a) County 1
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Park Lane Memorial Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 weeks
 (Specify whether
 In this community 3 wks.
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Lemay, Missouri
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3712 Paule ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Jacob A. Schmaltz 543
 3. (b) If veteran, name war None
 3. (c) Social Security No. 494-05-1593

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 10 1892
 (Month) (Day) (Year)

8. AGE: Years 47 Months 3 Days 25
 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Co. Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Maag Brick Co.

MOTHER FATHER
 { 12. Name Jacob Schmaltz
 { 13. Birthplace St. Louis Co. Mo.
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Rose Perrot
 { 15. Birthplace St. Louis Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rose Schmaltz

(b) Address 3712 Paule ave. Lemay, Mo.

17. (a) Burial (b) Date thereof Aug. 8. 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

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

(b) Address 7814 S. Broadway

19. (a) AUG 7 1939 (b) J. D. Braddock
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5
 year 1939 hour 2 minute 25 P. M.
 21. I hereby certify that I attended the deceased from July 17, 1939, to August 5, 1939;
 that I last saw him alive on August 5, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death hypertension in face blood
 Due to _____
 Due to _____

Other conditions _____
 (include pregnancy within 3 months of death)

Major findings: hypertension in face blood
 Of operations None
No other findings
 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 J. D. Braddock (M.D. or other)
 Address 4420 Bunker St. Date signed _____

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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broad

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.

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