

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.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 1800

1. PLACE OF DEATH: Feb. 12 1940

(a) County Saint Louis, Missouri.
 (b) City or town Saint Louis, Missouri.
 (c) Name of hospital or institution: 4469 Delor Street.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Anna Schuster

3. (b) If veteran, name war _____
 3. (c) Social Security No. None

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

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

7. Birth date of deceased May 22nd, 1857.
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>8</u>	<u>26</u>	hr. min.

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

10. Usual occupation House-Wife.

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown Ireland
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Laura M. Parony

(b) Address 4469 Delor Street.

17. (a) Burial (b) Date thereof Feb. 22nd, 40.
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pauls Churchyard.

18. (a) Signature of funeral director Ziegenhain Bros
 (b) Address 2623 Cherokee Street.

19. (a) FEB 21 1940 (b) _____
 (Date of death) (Date of registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County _____
 (c) City or town Saint Louis.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4469 Delor Street.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 18th,
 year 1940. hour 3 minute 0 P. M.

21. I hereby certify that I attended the deceased from Jan. 20, 1940, to Feb. 18, 1940
 that I last saw her alive on Feb. 18, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
 Due to Carcinoma of Rt. Parotid & General Metastasis.
 Other conditions (Include pregnancy within 3 months of death) _____

Duration 2 d.
5 months

Major findings: Grade IV Ca. of pt. parotid & extension thru capsule.
 Of autopsy no autopsy

PHYSICIAN _____
 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 John A. Pirant (M. D. or other) M.D.
 Address 3902 Russell Date signed 2-19-40

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.....

W E Morris

Licensed Embalmer No. *3360*

P. O. Address *2623 Cherokee*

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.