

MAY 15 1940

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **3165**

1. PLACE OF DEATH:

(a) County **5193 VERNON**
 (b) City or town **ST LOUIS MO**
 (c) Name of hospital or institution:
5193 VERNON AVE
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **Life**
 years, months or days

8. (a) PRINT FULL NAME **HENRY SCHLUETTER**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **MARRIED**

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

7. Birth date of deceased **2-23-1857**
 (Month) (Day) (Year)

8. AGE: Years **83** Months **1** Days **11** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Cabinet Maker**

11. Industry or business **retired**

12. Name **Henry Schluetter**

13. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

14. Maiden name **ANNIE (MARRIAGE)**

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

16. (a) Informant's own signature **Anthony Schluetter**

(b) Address **5193 VERNON**

17. (a) **Burial** (b) Date thereof **4/6/40**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY**

18. (a) Signature of funeral director **Sullivan**

(b) Address **2849 NO EUSTIS**

19. (a) **APR 5 1940** (b) **J.P. Braddock**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **City**
 (c) City or town **St Louis Mo 5**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5193 VERNON**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **4**
 year **1940** hour **4:15 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **Jan. 9-1940**
 _____, 19____, to **April 4**, 19**40**;
 that I last saw him alive on **April 4**, 19**40**,
 and that death occurred on the date and hour stated above.

Immediate cause of death
acute Myocarditis result of
chronic myocarditis
 Due to **acute Prostatitis**
arterio-sclerosis
 Due to **Senility**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93c**
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Dr. Leo P. Young** (M. D. or other) _____
 Address **2621 S. Jefferson** Date signed **4/6/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FORM 8-17-39 REV. 1-1-39

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.

Dr. J. Young
2621 D. Jefferson

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 *Albert Mayfield*
Licensed Embalmer No. *3077*
P. O. Address.....

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.