

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.

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(c) Name of hospital or institution: 3 Days Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days  
In this community 3 Days (Specify whether years, months or days)

8. (a) PRINT FULL NAME Odelia D. Schmitt 530  
8. (b) If veteran, name war \*\*\*\*\*  
8. (c) Social Security No. \*\*\*\*\*

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \*\*\*\*\*  
6. (c) Age of husband or wife if alive \*\*\* years  
7. Birth date of deceased September 24 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 7 3 hr. min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Victor Schmitt  
13. Birthplace France  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clara Palsch  
(b) Address 3404 1/2 Reservoir Dr

17. (a) Burial (b) Date thereof 10 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Péetz Brothers  
(b) Address 3029 Lafayette Ave

19. (a) APR 30 1940 (b) J. P. Schmitt  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town University City Mo NR  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6600 Washington Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th  
year 1940 hour 8:55 minute P. M.

21. I hereby certify that I attended the deceased from July 10, 1922, to April 27, 1940  
that I last saw her alive on April 27, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Idiopathic Falcine Hemiparesis 3 days  
Hypertension Arteriosclerosis 20 yrs  
Due to \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: None  
Of operations None  
Of autopsy None  
Symptoms

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 Edmond Bournot (M. D. or other) MD  
Address 1504 So Grand Date signed 4/29/40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

On 10/10/1941  
6 75 8 00  
H. H. & P. H.

**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: Paul J. Owen  
Licensed Embalmer No. 2345  
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.**