

10-39
SEP 25 1940

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7040**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1913 - No 13 - near **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis **26**
(If outside city or town limits, write "RURAL")
(d) Street No. 1913 - No 13 - near
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18
year 1940 hour 8:15 minute 07 AM M.

21. I hereby certify that I attended the deceased from 7-10 -, 1940, to 8-16 -, 1940;
that I last saw her alive on 8-16 -, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Pulmonary Tuberculosis **1 yr.**

Due to _____
Due to _____

Other conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
1 yr.
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 Robert E. Luyten MD (M. D. or other) _____
Address Robert K. Hospital Date signed 8/18/40

3. (a) PRINT FULL NAME Emma Schaub **100**

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

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

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

7. Birth date of deceased: 1 (Month) 15 (Day) 1881 (Year)

8. AGE: Years 59 Months 7 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Webermann
13. Birthplace St. Louis Missouri (City, town or county) (State or foreign country)
14. Maiden name Elizabeth Brandt
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Miss Anita Schaub

(b) Address 1913 - No. 13 - near
17. (a) BURIAL (b) Date thereof AUG 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FRIEDENS. CEM.

18. (a) Signature of funeral director Brookland and Co

(b) Address 1827 HOGAN STR

19. (a) AUG 20 1940 (b) _____
(Date received local registrar)

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

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

Robert W. Harper

Licensed Embalmer No. *1865*

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.