

REGISTRATION DISTRICT NO. **3036**

Primary Registration District No. **3036**

Registrar's No. **145**

1. PLACE OF DEATH

(a) County **St. Charles**
(b) City or town **St. Charles**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Joseph's Hospital**
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution **2 days** (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME **EDWARD SCHUBERT**

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

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

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

7. Birth date of deceased **Nov 7th 1870**
(Month) (Day) (Year)

8. AGE: Years **69** Months **9** Days **1** If less than one day _____ hr. _____ min.

9. Birthplace **St. Charles** (City, town, or county) **MO** (State or foreign country)

10. Usual occupation **Merchant**

11. Industry or business

MOTHER FATHER { 12. Name **John B Schubert**
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name **Caroline Pfister**
15. Birthplace **St. Louis Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Laura M. Schubert**
(b) Address **St. Charles, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug 11, 1940** (Month) (Day) (Year)
(c) Place: burial or cremation **St. John Cemetery**

18. (a) Signature of funeral director **H. K. ...**
(b) Address **326 N. 6th St. St. Charles Mo**

19. (a) **8/9/40** (Date received local registrar) (b) **Clarence B. Hesse** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Charles**
(c) City or town **St. Charles** (If outside city or town limits, write "RURAL")
(d) Street No. **230 N. Main St** (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **8th** year **1940** hour **11** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **Aug. 1st** 1940, to **Aug 8** 1940;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremic Poison**
Due to **No felicit** Duration **from history 4 months**

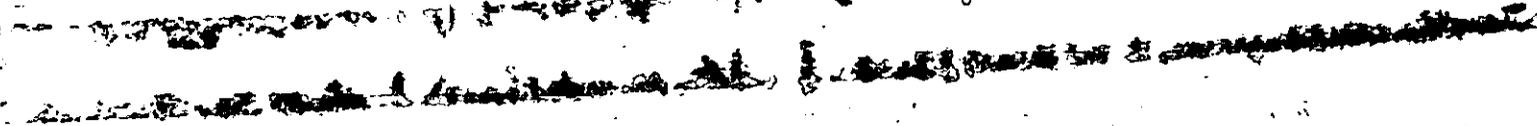
Due to _____
Other conditions **Kindred's App. Schmitt**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? **67th**
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **J. P. ...** (M. D. or other) !
Address **St. Charles Mo** Date signed **8-10-40**

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

1320



Wm. J. ...
...

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 *Arthur C. Bane*
Licensed Embalmer No. *3147*
P. O. Address *St. Charles 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29490

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 757

Primary Registration District No. 2036

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Edward Schubert

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 1 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug day 9 year 1990 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death uremic
poison

Due to nephritis Chronic

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration
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 J R Nardin (M. D. or other) _____

Address St Charles MO Date signed 2-7-1991

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

SUPPLEMENTAL COPY

