

FILED FEB 1 1943 18

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County **ST. LOUIS**

(b) City or town **ST. LOUIS**

(c) Name of hospital or institution: **City Hospital**

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **MO** (b) County **100**

(c) City or town **ST. LOUIS** **12**

(d) Street No. **7309 MINNESOTA** **19**

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **EARHARD HITTLER**

**3. (b) If veteran, name war** **NO**

**3. (c) Social Security No.** **NO**

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **1** day **22**

year **1943** hour **8** minute **06** AM.

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

**4. Sex** **MALE**

**5. Color or race** **WHITE**

**6. (a) Single, widowed, married, divorced, widowed** **WIDOWED**

**6. (b) Name of husband or wife** **FLORENCE**

**6. (c) Age of husband or wife if alive** \_\_\_\_\_ years

**7. Birth date of deceased:** **JULY 29 1867**

(Month) (Day) (Year)

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death: **Fracture Right Femur**

**Arteriosclerosis Suffered when he fell out of bed Jan 15-1943 at the Little sister of Rose**

Due to **3400 So Grand ave**

**8. AGE:**

Years	Months	Days	If less than one day
<b>75</b>	<b>5</b>	<b>24</b>	_____ hr. _____ min.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

**9. Birthplace:** **ST. LOUIS MO**

(City, town, or county) (State or foreign country)

**10. Usual occupation:** **TOBACCO WORKER**

Physician \_\_\_\_\_

**11. Industry or business**

**12. Name:** **UNKNOWN**

**13. Birthplace:** **UNKNOWN**

(City, town, or county) (State or foreign country)

**14. Maiden name:** **UNKNOWN**

**15. Birthplace:** **UNKNOWN**

(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**16. (a) Informant:** **Ruth Schaller**

(b) Address: **7309 Minnesota**

**17. (a) BURIAL** (b) Date thereof: **1/25/42**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **SS. PETER & PAUL CH**

**18. (a) Signature of funeral director:** **J. J. Brudsh**

(b) Address: **2128 J. J. Brudsh**

**19. (a) JAN 23 1943** (Date received local registrar)

(Registrar's signature)

**22. If death was due to external causes, fill in the following:**

(a) Accident, suicide, or homicide (specify) **Accidents**

(b) Date of occurrence: **1-15-43**

(c) Where did injury occur? **St. Louis MO**

(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury: \_\_\_\_\_

**23. Signature:** **Thos. J. Callahan**

Address: **Deputy Coroner** Date signed: **2-2-43**

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

MOTHER FATHER

**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.....

*Harry J. Schumacher*

Licensed Embalmer No.....

*2679*

P. O. Address.....

*732 Pennsylvania*

**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, fact should be so stated above.**