

FILED AUG 21 1944 318

L1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 6987

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis City Hospital  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 17

(d) Street No. 4530 Natural Bridge Ave.  
(If rural, give location) 9/10

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

If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME GEORGE SCHLEGEL

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. 333-01-9542

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 7th  
year 1944 hour 5 minute 00 P. M.

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Adele Schlegel

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased: May 1st, 1879  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to Aug. 7th, 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 3 Days 6 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death: Cerebral hemorrhage

Duration \_\_\_\_\_

9. Birthplace: St. Louis, Mo.  
(City, town, or county) (State or foreign country)

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

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

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

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

10. Usual occupation: Woodworker

11. Industry or business: Commonwealth Steel Co.

MOTHER FATHER { 12. Name Albin Schlegel

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

14. Maiden name Elizabeth Bushnell

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Adele Schlegel

(b) Address 4530 Natural Bridge Ave.

17. (a) Burial (b) Date thereof 8-10-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Provost Und. Co.

(b) Address 3710 N. Grand Blvd.

19. (a) AUG 10 1944 (Date received local registrar)

J. F. Bredes (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature J. F. Bredes (Date signed) 8/10/44

Address 1515 Lafayette

**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 L. Brinkman*

Licensed Embalmer No. *3553*

P. O. Address *3110 N Grand*

**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.**