

FILED OCT 20 1944 318

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

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

1003

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

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:  
City Infirmary  
(If not in hospital or institution, write street number or location)  
3 1/2 Mo.  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Julius Schmidt

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Cecelia Cecelia Schmidt 6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased Dec 20, 1881  
(Month) (Day) (Year)

8. AGE: Years 62 Months 7 Days 16 If less than one day  
hr. \_\_\_\_\_ min.

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

10. Usual occupation Miner

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

MOTHER FATHER

12. Name Herman Schmidt  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Willi  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Cecelia Schmidt  
(b) Address 4441 LaClede

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-7-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Breeze Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave

19. (a) OCT 10 1944 (Date received local registrar) (b) J. F. Brudeck (Registrar's signature)

544 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4441 LaClede Ave  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country American

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~XIII~~ Oct., 6, 1944  
year 1944 hour 3:05 p.m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 28-44  
Oct. 6, 1944 to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on Oct. 6, 1944, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
General Arterio Sclerosis  
Central Nervous System Sepsis (Purulent)  
Hypertension  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 320

Major findings: Of operations \_\_\_\_\_

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

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? \_\_\_\_\_

(Specify type of plane)  
While at work? \_\_\_\_\_ (b) Means of injury \_\_\_\_\_

23. Signature J. Mauer M. Law (M. D. or other) 10/7/44  
Address 5400 Grand Date signed \_\_\_\_\_

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

2098

2098

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**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

*Albert G. Hoppe*

Licensed Embalmer No.....

2971

P. O. Address.....

**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.**