

FILED DEC 15 1944 **318**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St Louis Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3525 N. 9 Th Str
(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)

3. (a) PRINT FULL NAME **Harold George Schuermann**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **488-14-0824**

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

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

7. Birth date of deceased **Dec 18 Th 1922**
(Month) (Day) (Year)

8. AGE: Years **21** Months **11** Days **15** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Truck Driver**

11. Industry or business **Franck Raffel Truck Co**

12. Name **Matthew Schuermann**

13. Birthplace **St Louis MO** (City, town, or county) (State or foreign country)

14. Maiden name **Catherin Sanders**

15. Birthplace **St Louis MO** (City, town, or county) (State or foreign country)

16. (a) Informant **Matthew Schuermann**

(b) Address **3525 N 9 TH Str**

17. (a) **Burial** (b) Date thereof **Dec 6 Th 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Edward Koch**

(b) Address **3516 N 14 Th Str**

19. (a) **DEC 5 1944** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St Louis**
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3525 N. 9th Str**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **3** year **1944** hour **5:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **8-21-1944** to **12-3-1944**
that I last saw him alive on **12-2-1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac dilatation** Duration **24 hrs**

Due to **Cardiac asthma** ?

Due to **Myocarditis, Chronic** ?

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

Major findings: Of operations **Abnormal Hypertrophic**

Of autopsy **None performed**

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 _____

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 injury) (e) Means of injury _____

23. Signature **Nicholas Martale** (M. D. or other) _____
Address **3861 St Louis Ave** Date signed **12/4/44**

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 John Ketter
.....

Licensed Embalmer No. 3880

P. O. Address St Louis 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, fact should be so stated above.