

FILED FEB 24 1945
Registration District No. **317**

Primary Registration District No. **3063**

Registrar's No. **408**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 1/2 days
(Specify whether
In this community 55 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Wellston **96**
(If outside city or town limits, write "RURAL")
(d) Street No. 6559 Joseph Avenue
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME DORA SCHOTT
3. (b) If veteran, name war nil
3. (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Robert Schott
6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
81 1 28 hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER
12. Name Krueger
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant St. Louis County Hospital
(b) Address 601 Brentwood Boulevard

17. (a) Burial (b) Date thereof 2 17 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director Guy Muller
(b) Address 504 Belmont

19. (a) **FEB 16 1945** (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day Fifteenth
year 1945 hour Twelve minute 40 A.M.

21. I hereby certify that I attended the deceased from January 30th 1945 to February 15, 1945;
that I last saw her alive on February 15th 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Peritonitis **1 wa**
Duration

Due to Ruptured Coeliac
Artery Obstruction (focal)

Other conditions Arteriosclerotic
(Include pregnancy within 3 months of death)
C-V Disease

Major findings: Ruptured Coeliac
Of operations
Of autopsy 100%
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 Thomas Alex M.D.
Address St. Louis County Hosp
(Date signed)

APR 25 1945

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.....
.....
working under my personal supervision.

Registered Apprentice No.

Signed

Howard F. Pauland

Licensed Embalmer No. 3114

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.