

**FILED** SEP 18 1945  
Registration District No. **SEP 18 1945**

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 Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St Anthony Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street 3001 Indiana Ave.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME JOSEPH SCHULLIER

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased Sept 7th 1945  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 9  
year 1945 hour 10 minute 30 a.m.

21. I hereby certify that I attended the deceased from Sept 7  
1945, to Sept 17 1945  
that I last saw him alive on Aug 7 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
hr. 10 Hours

Immediate cause of death:  
Myocardial infarction

Due to.....

Due to.....

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

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

10. Usual occupation Nil

11. Industry or business.....

MOTHER FATHER { 12. Name Joseph Schullier

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

14. Maiden name Viola Senf

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

16. (a) Informant Joseph Schullier  
(b) Address 3001 Indiana Ave.

17. (a) Burial (b) Date thereof Sept 8/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old S.S. Peter & Paul

18. (a) Signature of funeral director Thos. J. [unclear]  
(b) Address 2906 Gravois Ave.

19. (a) SEP 11 1945 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations.....

Of autopsy.....

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 Albert F. Bina (M. D. or other)  
Address 1841 L 12th Date signed 9/7/45

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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.....

Licensed Embalmer No. 14343

P. O. Address 2906 Garrison

**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.**