

State File No.

Registrar's No.

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-Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 2 days  
(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")

(d) Street No. 1201a Wright St  
(If rural, give location)

(e) Citizen of foreign country?..... 1 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME..... SALLIE SCHUETTE

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

4. Sex..... Female 5. Color or race..... White

6. (a) Single, widowed, married, divorced..... Widow ✓

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

7. Birth date of deceased..... Jan. 18, 1875  
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 7 If less than one day..... hr. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25th year 1945 hour 11:45 minute A. M.

21. I hereby certify that I attended the deceased from 9/23/45 19..... to 9/25/45 19.....  
that I last saw h. er alive on 9/25/45 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Bronchogenic Carcinoma of lung

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy..... Same

Duration.....

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

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

10. Usual occupation..... Proprietor Rooming House

11. Industry or business..... Domestic

MOTHER FATHER { 12. Name..... George Sparks

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

14. Maiden name..... Althea Kendrick

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

16. (a) Informant..... Ruth Murray  
(b) Address..... 8610 Strang Ave

17. (a)..... Burial (b) Date thereof..... 9/27/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Valhalla

18. (a) Signature of funeral director..... Robert J. Ambruster  
(b) Address..... 6633 Clayton Road

19. (a)..... SEP 26 1945 J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

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..... Herbert C. Zitt 1515 Lafayette 9/25/45  
(M. D. or other) (City or town) (Date signed)

**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 Arnold W. Schoene

Licensed Embalmer No. 3864

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.**