S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29377

FILED OCT 12 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8577

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: Barnes Hospital, 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17 14
(If outside city or town limits, write "RURAL")
(d) Street No. 5845 Itaska 9
(If rural, give location) 1
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARY LOU SCHURK

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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 10 (Month) 9 (Day) 1928 (Year)

8. AGE: Years 16 Months 11 Days 24 If less than one day hr. min.

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

10. Usual occupation Student

11. Industry or business

MOTHER FATHER

12. Name Joseph A Schurk

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

14. Maiden name Leona Schneider

15. Birthplace Milwaukee (City, town, or county) Wiscounsin (State or foreign country)

16. (a) Informant Joseph A Schurk
(b) Address 5845 Itaska, St. Louis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-1945 (Month) (Day) (Year)
(c) Place: burial or cremation New S S Peter & Paul

C. HOFFMEISTER COLONIAL MORTUARY

18. (a) Signature of funeral director
(b) Address 6464 Chippewa, St. Louis, Mo.

19. (a) OCT 4 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3
year 1945 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct. 1, 1945, 19..., to Oct. 3, 1945; that I last saw he alive on Oct. 3, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death BRAIN TUMOR, ~~probable~~, astrocytoma, involving frontal lobe

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Craniotomy
Of autopsy As above

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature M Bradley O (M. D. or other)
Address Barnes Hospital, Date signed 10/3

(Licensed Embalmer's Statement on Reverse Side)

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. Louis C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadw

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.