

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 308

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 624 So Liberty /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 25 years
(Specify whether years, months or days)

In this community: 25 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence
(If outside city or town limits, write "RURAL")

(d) Street No. 624 So Liberty
(If rural, give location)

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

3. (a) PRINT FULL NAME Gustav H. Schuster

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26
year 1945 hour 11 minute _____ P.M.

4. Sex male 5. Color or race white

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

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: July 14 - 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 23 - 1944 to Oct 27 - 1945

that I last saw him alive on Oct 26 - 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Valvular Heart Disease
Duration 16 years

8. AGE: Years 78 Months 3 Days 12
If less than one day hr. _____ min. _____

Due to Rheumatic

Due to _____

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

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

Major findings: Of operations no operation

Of autopsy no autopsy

10. Usual occupation Carpenter

11. Industry or business _____

12. Name John J. Schuster

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

14. Maiden name Unknown

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Nora Bouman

(b) Address 619 So. Liberty

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Oct 29 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Woodlawn Cemetery

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

18. (a) Signature of funeral director Ott + Mitchell

(b) Address 310 N Main Ind. Mo

23. Signature W. Allen M.D. (M. D. or other) MD

19. (a) 10-27-45 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

Address Independence Date signed Oct 27 - 45

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

844

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 me

..... Registered Apprentice No.
working under my personal supervision.

Signed Henry S. Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep 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.