S. No. 2
M—2-43
. 5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39771

FILED JAN 31 1946

Registration District No. 1003

Primary Registration District No.

Registrar's No. 11513

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: St. Louis Children's 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)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Clinton

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Joseph Bernard Schuette

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 15 (Day) 1945 (Year)

8. AGE: Years 0 | Months 1 | Days 5 | If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER

12. Name Bernard Schuette

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

14. Maiden name Laura Buehne

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

16. (a) Informant Bernard Schuette

(b) Address Breese, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-21-45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Rose, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) DEC 27 1945 (Date received local registrar) J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 20th year 1945 hour 8:30 minute P. M.

21. I hereby certify that I attended the deceased from 12-3-45, 19, to 12-20-, 1945; that I last saw him alive on 12-20, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. J. Bettner (M. D. or other)

Address for R. Kingsley Date signed

(Licensed Embalmer's Statement on Reverse Side)

11413

11413

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. 3575

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.