

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4135

FILED JAN 21 1946

State File No. _____

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 145

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution:
4808 EDGEWOOD AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 7 MONTHS (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

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

(d) Street No. 4808 EDGEWOOD AVE
(If rural, give location)

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

3. (a) PRINT FULL NAME JOHN B. SCHLUETER

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife ANNA SCHLUETER

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

7. Birth date of deceased JUNE 15 1864
(Month) (Day) (Year)

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

81 7 1 hr. min.

9. Birthplace GERMANTOWN ILL
(City, town, or county) (State or foreign country)

10. Usual occupation AUTO TRIMMER

11. Industry or business _____

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant Mrs. Mary Perlow

(b) Address 4808 Edgewood ave

17. (a) BURIAL (b) Date thereof 1-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a)' Signature of funeral director J. B. Tanner

(b) Address 6107 Natural Bridge

19. (a) 1-17-46 (b) E. B. McConaha
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16
year 1946 hour 2:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from OCT 3, 1945, to Jan 16, 1946
that I last saw him alive on Jan 12, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate

Due to _____

Due to _____

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

Major findings: _____

Of operations: _____

Of autopsy: _____

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 Albert Wall (M. D. or other) M.D
Address 5322 Helen Ave Date signed 1/16/46

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

MOTHER FATHER

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

Henry M. Brammer

Licensed Embalmer No. 4200

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.