

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18195

FILED MAY 27 1946

Registration District No. 317

Primary Registration District No. 6026

Registrar's No. 1080

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Rural
(c) Name of hospital or institution:
North of Airport, St. Louis County
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Raymond H. Schott
3. (b) If veteran, name war yes
3. (c) Social Security No. none
4. Sex male
5. Color or race white
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 March 4th. 1927
(Month) (Day) (Year)

8. AGE: Years 19 Months 2 Days 12
If less than one day hr. min.

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

10. Usual occupation

11. Industry or business St. Louis Butcher Supply

12. Name Rudolph Schott

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

14. Maiden name Mary Streb
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Mary Schott Forshee

(b) Address 1424 Benton St.

17. (a) (Burial, cremation, or removal) (b) Date thereof 5-20-46
(Month) (Day) (Year)

(c) Place: burial or cremation Dixon, Missouri

18. (a) Signature of funeral director Hy. Leidner U. Co.

(b) Address 2223 St. Louis Ave

19. (a) 5-18-46 (b) E. J. McGeary
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County oao
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1424 Benton St. 9
(If rural, give location)
(e) Citizen of foreign country? 1
(Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16th
year 1946 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date and hour stated above.

Immediate cause of death Skull fracture

Due to Automobile accident - 20

Due to plunged over embankment,

no other car involved.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

XXXXXX

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

(a) Accident, suicide, or homicide (specify) Accident 96

(b) Date of occurrence 5/16/46

(c) Where did injury occur? Robertson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Public road

(Specify type of place)

While at work? Means of injury Blunt im-

Signature Arnold J. Willmann

Address Clayton, Mo.

Date signed 5/18/46

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

John P. Buckholz

Licensed Embalmer No. *1674*

2223
P. O. Address. *St. Louis*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 317Primary Registration District No. 6076Registrar's No. 1080

1. PLACE OF DEATH:

- (a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

3. (a) PRINT
FULL NAME Raymond H. Schott

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 S

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

7. Birth date of deceased Mar 4
(Month) (Day) (Year)

8. AGE: Years 19 Months 2 Days 2 (If less than one day, hr. min.)

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

10. Usual occupation

11. Industry or business

- MOTHER FATHER { 12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) John J. Gorman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 sta-
tistically.

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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