

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED MAY 27 1946 STANDARD CERTIFICATE OF DEATH

State File No. 18884
Registrar's No. 4362

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis Mo
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 4120 No Taylor Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 67 (Specify whether years, months or days)

3. (a) PRINT FULL NAME MICHAEL J. SCHULTZ

3. (b) If veteran, No name war 3. (c) Social Security No

4. Sex Male 5. Color or white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Emma Duerr
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased April 24 1879
(Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 19 If less than one day hr. min.

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

10. Usual occupation FUNERAL DIRECTOR

11. Industry or business Undertaking

12. Name Barnard Schultz
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Sheehan
15. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Emma Schultz
(b) Address 4120 No Taylor Ave
(c) Place: burial or cremation Burial
(Burial, cremation, or removal) (b) Date thereof 5/16/1946
(Month) (Day) (Year)

18. (a) Signature of funeral director W. J. Weidenmeyer
(b) Address 620 1/2 3rd St
(c) Place: burial or cremation Sunsett Burial Park

19. (a) MAY 15 1946 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Louis Mo (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No 4120 No Taylor
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 1946 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from April 17 to May 13
that I last saw him alive on May 13
and that death occurred on the date and hour stated above.

Immediate cause of death Radio Recal Fascium
Nervous Duration 4 yrs

Due to.

Due to. Radio Recal Fascium
(Include pregnancy within 3 months of death)

Major findings: 13/12
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?

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

23. Signature O. J. Aschmeyer (M. D. or other)
Address 1100 Maryland Date signed 5/13/46
Ambrose

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

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.....

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.