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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH
1003

State File No. 25712
Registrar's No. 6350

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town St. Louis
(c) Name of hospital or institution St. Louis City Hospital
Max C. Starkloff Memorial
(d) Length of stay: In hospital or institution 2 days
In this community 30 years

3. (a) PRINT FULL NAME LEROY SCHUMANN
(b) If veteran, name war no
(c) Social Security No. none

4. Sex M, race W
5. Color or race W
6. (a) Single, widowed, married, divorced M/
6. (b) Name of husband or wife Alma
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased September 12, 1888

8. AGE: Years 57, Months 10, Days 5

9. Birthplace Roodhouse, Illinois

10. Usual occupation druggist
11. Industry or business self

MOTHER FATHER
12. Name Jacob Schumann
13. Birthplace Luxemburg, Germany
14. Maiden name Susanne Taffner
15. Birthplace Germany

16. (a) Informant Alma Schumann
(b) Address 2713 Louisiana Avenue

17. (a) Burial, (b) Date thereof 7-19-46
(c) Place: burial or cremation Roodhouse, Illinois

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Av. St. Louis

19. (a) Date received local registrar JUL 19 1946
(b) Registrar's signature J. J. Brudeck

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri
(b) County
(c) City or town St. Louis
2713 Louisiana Avenue
(d) Street No. no
(e) Citizen of foreign country? no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July, day 17, year 1946, hour 12:45, minute A.M.
21. I hereby certify that I attended the deceased from July 14 to July 17, 1946
that I last saw him alive on July 17, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Cardiovascular Disease
Due to
Due to
Other conditions
Major findings:
Of operations
Of autopsy

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
23. Signature of physician [Signature]
Address 1515 Lafayette Avenue Date signed 7/17/46

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..... *C W Cooper*

Licensed Embalmer No. *3830*

P. O. Address. *2301 Lafayette Ave*

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.