

No. 2  
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5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** *Oct 21 1946*  
**318**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35586  
State File No. **8630**  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

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: Alexian Bros. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3723a Connecticut  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Hugo T. Schulte  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 6  
year 1946 hour 11 minute 55P. M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widower  
(b) Name of husband or wife Mary  
(c) Age of husband or wife if alive -- years  
7. Birth date of deceased Nov. 19 1873  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10/10/46 to 10/16/46  
that I last saw him alive on 10/16/46 and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral appoplexy  
Duration 4 days

8. AGE: Years 73 Months 10 Days 17  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to arterio-sclerosis  
Other conditions As follows in Hospital for Prosthetics for under 2 weeks under Dr. M. S. Moon  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Retired  
11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy None  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Albert L. O'Rourke  
(b) Address 3723a Connecticut  
17. (a) Burial (b) Date thereof 10/9/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Old St. Marcus  
18. (a) Signature of funeral director Wacker Hildrich  
(b) Address 3634 Gravois Ave.  
19. (a) OCT 8 1946 (Registrar's signature) (Date received by Registrar)

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) (e) Means of injury 2  
23. Signature Barbara (M.D. or other) \_\_\_\_\_  
Address 2844 Oak Date signed 10/7/46

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

MOTHER FATHER

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**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.....

*Robert Wheeler*

Licensed Embalmer No. *2178*

P. O. Address.....  
*St Louis Mo*

**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.**