

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 1 1948
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 15631
Registrar's No. 4143

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town _____
(c) Name of hospital or institution:
6730 CLAYTON Ave
(d) Length of stay: In hospital or institution _____
In this community 60 Yrs. (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis
(d) Street No. 6730 CLAYTON
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MAGDALENA SCHUESSLER
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Fe 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife KEY F. SCHUESSLER
6. (c) Age of husband or wife if alive + years
7. Birth date of deceased MAR 19 1866

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr. day 19th year 1947 hour 2 minute 36 P. M.
21. I hereby certify that I attended the deceased from Dec 37, to April 18th, 1947;
that I last saw her alive on April 18th, 1947;
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Hemorrhage
Due to Hypertension
Arteriosclerosis
Myocarditis Hypertensive

8. AGE: Years 81 Months 1 Days 0
If less than one day _____ hr. _____ min.

Duration 10 years
Duration "
Duration "

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

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

11. Industry or business _____

Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER
12. Name FREDERICK KOESTERING
13. Birthplace GERMANY
14. Maiden name UNKNOWN
15. Birthplace _____

PHYSICIAN
Underline the cause to which death should be charged statistically.
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16. (a) Informant Mrs Adolph Schuessler
(b) Address 6730 Clayton

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Apr. 26 1947
(Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation New Belle Ken

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

18. (a) Signature of funeral director Blutewiden Funeral Home
(b) Address 1936 St. Louis Ave

23. Signature Arnold Klein (M. D. or other) _____
Address 2632 S. Kings Highway Date signed 4/21/47

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

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..... *Delis J. Krupin*.....
Licensed Embalmer No..... *3497*.....
P. O. Address..... *1936 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.