No. 2
1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 23 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32999

Registrar's No. 3677

**1. PLACE OF DEATH:**

(a) County

(b) City or town: St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street, number or location)

(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: 000

(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No.: 2750a Russell Blvd. 9
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: ETHEL SCHULZ

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Louis

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Dec. (Month) 22, (Day) 1891 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 8 | 21 | hr. min. |

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

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Florenz Haggard
13. Birthplace: (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Louis Schulz
(b) Address: 2750a Russell Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 16-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Geeck Funeral Home
(b) Address: 3029 Lafayette Ave.

19. (a) SEP 15 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month: Sept. day: 13th year: 1947 hour: 1 minute: 05 P. M.

21. I hereby certify that I attended the deceased from Sept. 11, 1947 to Sept. 13, 1947 that I last saw her alive on Sept. 13, 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Asthma | |
| Due to: Chronic Bronchial Asthma | |
| Pulmonary Emphysema | 5 yrs |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: | |
| Of autopsy: | |

PHYSICIAN — Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: A W Peters (M. D. or other) M.D.

Address: 4145 a S. Grand Blvd. Date signed: 9/15/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side).

Dr Peters.
Ge and Mar.
2-4.

4145 A-S. G.

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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address 3029 Lafayette

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.

S. No. 2B
M—3-45
Exp I'X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 062

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6677

**1. PLACE OF DEATH:**

(a) County

(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 years, months or days)
In this community

**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

3. (a) PRINT FULL NAME Ethel Schulz

3. (b) If veteran, name war

3. (c) Social Security No. 0

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 22 1899
(Month) (Day) (Year)

8. AGE: Years 55 Months 8 Days If less than one day hr. min.

9. Birthplace Brookfield, 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredlock (Registrar's signature)
OCT 10 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept Day 3 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h 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 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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

32999

[illegible]