S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33001

FILED SEP 18 1947 #76370

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8401

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

1. PLACE OF DEATH:

(a) County

(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: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 2130 Stansbury St. 9
Memorial (If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 24

3. (a) PRINT FULL NAME GOTTFRIED SCHUSTER

3. (b) If veteran, name war No

3. (c) Social Security No. 489-07-8278

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Martha Schuster

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased April 27 1883 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	4	6	hr. min.

9. Birthplace Germany (City, town, or county) 4 (State or foreign country)

10. Usual occupation Bartender

11. Industry or business

FATHER
12. Name Joseph Schuster 4
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Genevieve Wild
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant Martha Schuster
(b) Address 2130 Stansbury

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-47 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Will Brown R. & U. Co
(b) Address 2929 S. Jefferson Av.

19. (a) SEP 4 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3rd year 1947 hour 3:30 minute A M.

21. I hereby certify that I attended the deceased from 8/12/47, 19, to Sept. 3rd 1947; that I last saw him alive on Sept. 3rd 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral vascular accident — Duration: 20 days

Due to: Arteriosclerosis

Due to:

Other conditions: Hypertensive cardio-vascular disease
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

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 Frank F. Martin (M.D. or other)
Address 1515 Lafayette Date signed 9/3/47 3 Sept 47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Harold C. Witt

Licensed Embalmer No. 4353

P. O. Address 2929 S. Jefferson 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.