

FILED SEP 16 1949

STANDARD CERTIFICATE OF DEATH

31079

State File No.

BIRTH NO. REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 293

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) Hannibal		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) Hannibal		d. STREET ADDRESS (If rural, give location) 2900 Hubbard Street	
3. NAME OF DECEASED (Type or Print) Edward P. Schultz			4. DATE OF DEATH (Month) (Day) (Year) September 3, 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 19, 1870
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Hannibal Missouri
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Furniture	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Henry C. Schultz		13b. MOTHER'S MAIDEN NAME Catherine List	14. NAME OF HUSBAND OR WIFE May Crain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME S.F. Schultz ADDRESS Hannibal Missouri
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 8 or 10 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Aneurysm II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION Aug. 10 - 49	19b. MAJOR FINDINGS OF OPERATION Carcinoma of Prostate		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 20 , 19 48 , to Sept 3 , 19 49 , that I last saw the deceased alive on Sept 3 , 19 49 , and that death occurred at 10:15 m. , from the causes and on the date stated above.			
23a. SIGNATURE W. B. Blue R. M.D. (Degree or title)		23b. ADDRESS Hannibal Mo	23c. DATE SIGNED Sept 7 - 49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/6/1949	24c. NAME OF CEMETERY OR CREMATORY Mount Olivet	24d. LOCATION (City, town, or county) (State) Hannibal Missouri
DATE REC'D BY LOCAL REG. 9-8-49	REGISTRAR'S SIGNATURE Dr. E. M. Lucid	FUNERAL DIRECTOR'S SIGNATURE W. B. Blue ADDRESS Hannibal Missouri	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Signed W. Bradford Smith

Signed.....
Student Embalmer

Licensed Embalmer No. 3814

P. O. Address Hannibal Missouri

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.