

FILED NOV 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36215  
State File No. 194

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 3002 Registrar's No. 194

1. PLACE OF DEATH a. COUNTY <b>Audra in</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Mad</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Mexico</b> )	c. LENGTH OF STAY (In this place) <b>3</b> townships) <b>18 hrs.</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>City Of St. Louis</b> <b>17</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Hoxsey Hotel</b>		d. STREET ADDRESS (If rural, give location) <b>6940 Pasadena Blvd.</b> <b>9</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Lawrence H. Schuler</b>	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 17, 1949</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 14, 1904</b>	9. AGE (In years last birthday) <b>45</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 6 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Refrigeration</b>	11. BIRTHPLACE (State or foreign country) <b>Portsmouth, Ohio</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
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13a. FATHER'S NAME <b>John Schuler</b>	13b. MOTHER'S MAIDEN NAME <b>Not Known</b>	14. NAME OF HUSBAND OR WIFE <b>Verna Schuber</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>363-05-0080</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Verna Schuber</b> ADDRESS <b>St. Louis, Mo.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Anguish found dead in bed.</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cause Unknown, no evidence of</b> DUE TO (c) <b>violence or foul play or indicated</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>of person. Victim's Natural Cause</b>			

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>Dr. J. J. &amp; Council.</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Natural Cause</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Mexico, Audrain, Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>7955</b>
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22. I hereby certify that I attended the deceased from **Council Case August 11-18, 1949**, that I last saw the deceased alive on **11-18-49**, and that death occurred at **12:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>L. C. Adams M.D. Council</b> (Doctor or title)	23b. ADDRESS <b>Mexico, Missouri</b>	23c. DATE SIGNED <b>11-18-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Nov 18th, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Louis, Mo.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Nov 18-1949</b>	REGISTRAR'S SIGNATURE <b>Blanche Neely</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Clara C. ...</b> ADDRESS <b>...</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

4  
1  
2

6761 72 030

DEC 27 1949

APR 20 1950

MAR 27 1950

RECEIVED NOV 21 1949  
District Health Officer No. 10  
District File Number 11-49-12  
Date Filed NOV 21 1949

STATEMENT BY LICENSED EMBALMER

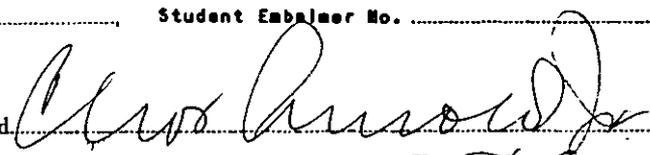
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....  
working under my personal supervision.

..... Student Embalmer No. ....

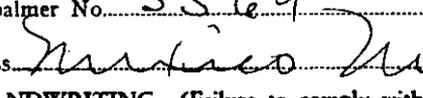
Student .....  
Student Embalmer

Signed.....



Licensed Embalmer No. 3569

P. O. Address.....



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.