

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 26 1954

State File No. **35944**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9138**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 4333 Wilcox		e. STREET ADDRESS (If rural, give location) 15 4333 Wilcox 215-9	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Schulenburg c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Oct. 7, 1954
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Sept. 18, 1887	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. 25 yrs		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Wm. Schulenburg	13b. MOTHER'S MAIDEN NAME Annie Ernst	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or date of service) World War I	16. SOCIAL SECURITY NO. unk	17. INFORMANT'S SIGNATURE OR NAME Annie W. Schulenburg ADDRESS 4333 Wilcox
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 71X-X30		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Renal hematuria due to unknown causes		
	II. OTHER SIGNIFICANT CONDITIONS Paralysis Agitans 946.4-953		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 350X

22. I hereby certify that I attended the deceased from **8/19, 1953** to **10/7, 1954**, that I last saw the deceased alive on **10/7, 1954**, and that death occurred at **25p** m., from the causes and on the date stated above.

23a. SIGNATURE Saul F. McRae, D.O. (Degree or title)	23b. ADDRESS 4407 S. Kingshighway	23c. DATE SIGNED 10/8/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 10-11-54	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. OCT 8 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home ADDRESS 6322 S. Grand Blvd., St. Louis, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Paul McRae
4407 S. Kingshighway
about 130

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..

Student.....
Signature of Student Embalmer

Signed..... *David Paul Jossan*

Licensed Embalmer No. 4247

P. O. Address 6322 1/2 St

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.