No. 2
-8-43
-17-39
X37823

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. 41896

FILED JAN 12 1946

Registration District No. 22 — Primary Registration District No. 3046 5796 — Registrar's No. 33

1. PLACE OF DEATH:

(a) County Monteau
(b) City or town Rural Walton Tp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6 mi. north of California, Mo.
(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 Monteau 68
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No. 6 mi. north of California, Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Gotlieb Louis Schuster
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married divorced married
6. (b) Name of husband or wife Ethel F. Griesbach Schuster
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Jan. 20 1868 (Month) (Day) (Year)

8. AGE: Years 77 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Moniteau Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation retired farmer
11. Industry or business

MOTHER FATHER
12. Name John William Schuster
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name ~~Unknown~~ Anna E. Schottle
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Bryde Schuster
(b) Address California, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Moniteau Evangelical Cemetery
18. (a) Signature of funeral director A. E. Wilson
(b) Address California, Mo.
19. (a) 1-5-46 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1945 hour 8 minute 30 P.M.
21. I hereby certify that I attended the deceased from Feb. 8, 1944 to Dec 29, 1945 that I last saw him alive on Dec 28, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Arteriosclerosis	
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 2

23. Signature [illegible] (M. D. or other) D.O
Address California Date signed 1/2/46

1524 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 1-11-46

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 A. E. Wilson

Licensed Embalmer No. 2351

P. O. Address California Me.

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
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 724 Primary Registration District No. 5796 Registrar's No. 33

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

1. PLACE OF DEATH:
(a) County Moniteau
(b) City or town Rural
(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 Gotlieb L. Schuster
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
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 Jan 20, 1868 (Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days If less than one day hr. min.

9. Birthplace Ger. (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

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

MOTHER
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) 12-30-05 (Date received local registrar) (b) H. R. Rofoyay (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 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.

	Duration
Immediate cause of death	
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

41896