N. B.—Every item of information should be carefully supplied. AGE should be stated ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1928

1. PLACE OF DEATH

County: St Louis County — Registration District No. 1123 — File No. 34660

Township: Carondelet — Primary Registration District No. 6248 — Registered No. 389

City: ..... (No. 105 Horn Av St. ..... Ward)

2. FULL NAME Alonzo Schnellmann

(a) Residence. No. 105 Horn Av St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Marie Schnellmann

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June — 1854

7. AGE: Years 73 — Months 4 — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Darry man
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Switzerland

PARENTS

10. NAME OF FATHER: Alonzo Schnellmann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Switzerland
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Switzerland

14. INFORMANT: Louis Schnellmann
(Address) 7200 Vermont Av

15. Filed Nov 8, 1927 L. C. Obrock, Registrar

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 6 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1927, to Nov 6, 1927, that I last saw h..... alive on Nov. 6, 1927, and that death occurred, on the date stated above, at 11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis partial paralysis semi.
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY): Operated right side for Hernia, complete & Anesthetic augmented
(duration) yrs. mos. ds.

the existing cause,

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Heriditary
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 13th 1927
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Observation & Affliti
(Signed) [signature], M. D.
, 19 (Address) 6330 Virginia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Olive — DATE OF BURIAL: Nov 9/27

20. UNDERTAKER: Fendler Med Co — ADDRESS: 7819 Mich

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St. Louis — Registration District No. 1123 — File No.
Township Carondelet — Primary Registration District No. 6248 E — Registered No. 389
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Alonis Schellmann
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	m

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 2 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	73			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED FEB 22 1928 L. C. Obrock M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 6 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SH... RECEI... CERTIFICATES ... THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-34660