28 1929

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

Do not use this space.

28832

1. PLACE OF DEATH
County: St. Louis — Registration District No. 1123 — File No.
Township: Carondelet — Primary Registration District No. 6248 A — Registered No. 293
City: (No. 8329 Bridge Av. St. Ward)

2. FULL NAME: Herman Schulte
(a) Residence. No. 8329 Bridge Av. 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 7 1855

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ___ hrs. or ___ min.
74	2	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(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): Germany

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

14. INFORMANT: Chas. Schulte
(Address) 8329 Bridge

15. FILED Aug 5, 1929 L. C. Obrock M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug. 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1929, to Aug 4, 1929, that I last saw him alive on 4 Aug, 1929, and that death occurred, on the date stated above, at 3.45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY): Infected left leg due to him cutting toe
(duration) yrs. mos. 1 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) Edward Todeter, M.D.
Aug 5, 1929 (Address) 7310 Michigan

*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: Calvary Cemetery — DATE OF BURIAL: Aug 7 1929

20. UNDERTAKER: Fenchler Und. Co. — ADDRESS: 7819 Mich.

N. B.—Every item of information should be carefully supplied. AGE 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
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH. County St Louis Registration District No. 123 a File No. .....
Township Carondelet Primary Registration District No. 6248 Registered No. 293
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Herman Schulte

(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	W

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

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

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

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 Aug 3, 1929 L. C. Obrock, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1929

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:
Septicemia
(Had a bruised toe & cut while walking.)
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Infected left leg due to him cutting toe
(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? 55
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

N. B.—Every item must be stated EXACTLY. PHYSICIANS and registrars should be stated EXACTLY. PHYSICIANS and registrars shall not receive a fee for any certificate of death which is not COMPLETE AS PRESCRIBED BY LAW. THIS IS A PERMANENT RECORD
CAUSE OF DEATH

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