

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

Do not use this space.

3022

1. PLACE OF DEATH

County St. Louis Mo
Township St. Louis Mo
City St. Louis Mo (No. 1005)

Registration District No. 791
Primary Registration District No. 1005

File No. 507
Registered No. 507
St. 9 Ward 1005

2. FULL NAME

(a) Residence. No. 2115 Adelaide St. 9 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 6 1902

7. AGE YEARS 28 MONTHS 8 DAYS 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Trucker 208N
(b) General nature of industry, business, or establishment in which employed (or employer) Truck
(c) Name of employer St. Louis

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Herman Schulte

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Brandt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Marguerite Schulte
(Address) 2115 Adelaide

15. FILED JAN 16 1930 W. J. O'Sullivan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 30

17. No Physician in Attendance
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 _____, 19____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & bruise
Internal Concussion
of Brain Collision between
Street Car & Auto mos. ds.

CONTRIBUTORY St. Louis Mo.
(SECONDARY) Whether Criminal or yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Accidental Not
ascertained

IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. W. Turner, M.D.
116 1930 (Address) Def Coroner

*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 DATE OF BURIAL Jan 30

20. UNDERTAKER Street & Carroll ADDRESS 1600 Natl Bldg

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

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

