

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

Do not use this space.

**6879**

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... St. Louis..... Primary Registration District No. 003  
City..... St. Louis (No. St. Gabriel Hosp)..... St. .... Ward)

File No.....  
Registered No. 1720.....  
St. .... Ward)

**2. FULL NAME**

Theobald W. Schattler  
(a) Residence. No. 4546 Tower Grove Pl. 17 Ward.

(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 Lena Schattler

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 5 1896

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
<u>53</u>	<u>4</u>	<u>12</u>	

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

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

10. NAME OF FATHER..... unknown

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

12. MAIDEN NAME OF MOTHER..... unknown

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

14. INFORMANT..... Lena Schattler  
(Address)..... 4546 Tower Grove Pl.

15. FILED.....  
19.....  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-17 1930

I HEREBY CERTIFY, That I attended deceased from June 15, 1929 to Feb 17, 1930  
that I last saw him alive on Feb 17, 1930 and that death occurred, on the date stated above, at 9:40 am.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Myocarditis

131  
947  
93C

CONTRIBUTORY (duration) yrs. 8 mos. 2 ds.  
Angina Pectoris, Chronic  
Coronary Atherosclerosis, Dilatation of Aorta  
Cardiac Hypertrophy (duration) yrs. 8 mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED..... St. Johns Hospital

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? NO DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS..... X-Ray, ECG, Postmortem

(Signed)..... A. J. ... M. D.

Feb 18 1930 (Address)..... 1041 Mo Bldg

\*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..... Valhalla Cem

DATE OF BURIAL..... 2-19 1930

20. UNDERTAKER..... Kriegshauser Co 60 St. King Highway

ADDRESS 4228

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

10-1-223

Dr. Rammann 10  
Molecular Biology  
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