

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

Do not use this space.

10551

1. PLACE OF DEATH

County.....

Registration District No. **791**

1003

Township.....

Primary Registration District No.

City *St. Louis Mo.* (No. *4508 Adelaide Ave*)

File No.

Registered No. **2539**

St.

Ward)

2. FULL NAME *William F. Schlagmann*

(a) Residence No. *4508 Adelaide Ave* St. *10* 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 17 - 1862*

7. AGE

YEARS *67*

MONTHS *10*

DAYS *24*

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Shoe Business

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Louis Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Wm. Schlagmann

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Germany.

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Germany.

(STATE OR COUNTRY)

14.

INFORMANT

Louise Schlagmann

(Address)

4508 Adelaide Ave.

15.

FILED

..... 19.....

Max C. Harber
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 11 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 20*, 19*29*, to *Mar 11*, 19*30*, that I last saw him alive on *Mar 10*, 19*30*, and that death occurred, on the date stated above, at *7:50 P.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer Blood

51B

(duration) *5* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *Don't know*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *R. W. Dewey*

M. D.

3/12, 19*30*, (Address) *2342 St. Louis*

*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

St. Johns North.

Mar 14 1930

20. UNDERTAKER

ADDRESS *1417*

Max Leidner Third Cor. St. Market

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.

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