

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

Do not use this space.

10928

1. PLACE OF DEATH

County..... Registration District No. 701
Township..... Primary Registration District No. 1003
City St. Louis (No. 5051, Minerva St. _____ Ward)

File No. _____
Registered No. 2956

2. FULL NAME Thelma Schack

(a) Residence. No. 5051 Minerva St., 6 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 15 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 1 75

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(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) St. Louis

10. NAME OF FATHER Joseph Schack

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

12. MAIDEN NAME OF MOTHER Birdie Harris

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

14. INFORMANT Joseph Schack (Address) 1231 Summit st.

15. FILED 24 1930 May C. Staker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 22 1930

17. HEREBY CERTIFY, That I attended deceased from March 16 30 to March 22 30 that I last saw her alive on March 21, 1930, and that death occurred, on the date stated above, at 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
107A

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH no

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? physical

(Signed) J. H. P. [Signature] M. D.

Mar 23, 1930 (Address) 1446 S. Grand

*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

Evangelical Lutheran Cem 3/24 1930

20. UNDERTAKER ADDRESS 1936

Thos. H. Cieserwiler St. Louis

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.

1096

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

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

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

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 2956
St..... Ward.....

2. FULL NAME Thelma Schack

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>S</u> (write the word)
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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)

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

Max C. Stashky
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 22 19 30

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Primary - Pneumonia
Secondary - Whooping cough
Information given over Phone by
Dr. H. O. Lee, Peck, Mo. of U.S. 5-9-30

CONTRIBUTORY (SECONDARY)

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

20. UNDERTAKER

ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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