

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

Do not use this space.

14765

**1. PLACE OF DEATH**

County.....

Registration District No. 791  
1003

File No. ....

Township.....

Primary Registration District No. ISOLATION HOSPITAL

Registered No. 4174

City St. Louis, Mo. (No. ....)

St. .... Ward)

**2. FULL NAME**

Anthony Schulte

(a) Residence. No. 5029 Alabama 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)**

Married

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

Julia Anna Schulte  
5029 Cass Ave.

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

3-22-1878

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
52	1	3	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Cabinet Maker  
(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

**10. NAME OF FATHER** Jacob Schulte

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

**12. MAIDEN NAME OF MOTHER** Barbara Huber

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

**14. INFORMANT**

(Address) ISOLATION HOSPITAL

**15. FILED**

Apr 24 1930 W. C. Standley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 4-25-1930

**17. I HEREBY CERTIFY, That I attended deceased from** 4-22, 1930, to 4-25, 1930

that I last saw him alive on 4-24, 1930 and that death occurred, on the date stated above, at 2:15 A. m.

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

Meningitis, meningococci  
18

(duration) yrs. mos. 5 ds.

**CONTRIBUTORY (SECONDARY)**

24

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**8 DID AN OPERATION PRECEDE DEATH?** DATE OF.....

WAS THERE AN AUTOPSY?

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) Bel Kuebel, M. D.

(Address) ISOLATION HOSPITAL

\*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**

Sunset Burial Park Apr. 24 1930

**20. UNDERTAKER**

**ADDRESS**

Wacker Helder 7331 Broderly

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.

