

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.

NOV 28 1932

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

Do not use this space.

33439

1. PLACE OF DEATH

96 County St. Louis Registration District No. 189
Township Central Primary Registration District No. 6033 B
City (No. 8007 Albin Ave) St. Ward

File No.
Registered No. 286

2. FULL NAME

Frank X Schulenberg
(a) Residence, No. 8007 Albin Ave 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 Elizabeth Schulenberg
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 0 22
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Caretaker
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Golf Club 260
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis Co. 1
(STATE OR COUNTRY) Missouri

MOTHER FATHER 13. NAME August Schulenberg 1
14. BIRTHPLACE (CITY OR TOWN) ?
(STATE OR COUNTRY) Germany 10

15. MAIDEN NAME Mary Fischer

16. BIRTHPLACE (CITY OR TOWN) St. Louis Co. 1
(STATE OR COUNTRY) Missouri

17. INFORMANT Mrs. Elizabeth Schulenberg
(ADDRESS) 8007 Albin Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Ann's Comb. DATE Oct. 18 1932

19. UNDERTAKER Geo. L. Oleitich Inc.
(ADDRESS) 5966 Easton Ave.

20. FILED 10/16 1932 Specimen Registrar

✓ MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 15 1932

22. I HEREBY CERTIFY, That I attended deceased from Msy. 1 1932 to act 14 1932
I last saw him alive on Oct 14 1932 Death is said to have occurred on the date stated above, at 7:30 a.m.

The principal cause of death and related causes of importance were as follows:

carcinoma of throat Date of onset 2 year
458
97 458
arthritis

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

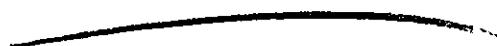
24. Was disease or injury in any way related to occupation of deceased?

If so, specify
(Signed) Rolla Percy M. D.
(Address) 6402 Easton Ave

State of Illinois
County of Cook

Notary Public
for the State of Illinois

Notary Public
for the State of Illinois



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis
Township Central
City (No. 9)

Registration District No. 789
Primary Registration District No. 6833 B

File No. _____
Registered No. 286
St. _____ Ward _____

2. FULL NAME

Frank F. Schulerberg

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-23-1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>59</u>	<u>-</u>	<u>22</u>	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER FATHER
13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER FATHER
15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 10-16 1932 Walter Bracy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 15 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

I last saw him alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

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.

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