

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

Do not use this space.

7521

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... **ISOLATION HOSPITAL**..... St..... Ward)

File No.....
Registered No. **1476**
St..... Ward)

2. FULL NAME

(a) Residence, No. **3407 Chestnut St. Bee 16** Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred **life** 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) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 21 - 1936		
7. AGE	YEARS 8	MONTHS 3
	DAYS 18	If LESS than 1 day, hrs. or min.
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) Mo		
MOTHER / FATHER	13. NAME Joseph Schulte	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo	
	15. MAIDEN NAME Joe Van Nida	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo	
17. INFORMANT (ADDRESS) ISOLATION HOSPITAL		
18. BURIAL, CREMATION, OR REMOVAL PLACE New St. Marys DATE 2-13 19 33		
19. UNDERTAKER (ADDRESS) Thieshauser Mortuaries		
20. FILED FEB 13 1933 Max Osterberg Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb 11, 1933**

22. I HEREBY CERTIFY, That I attended deceased from **Feb 1, 1933** to **Feb 11, 1933**

I last saw him alive on **Feb 11, 1933**. Death is said to have occurred on the date stated above, at **12:30 A.M.**

The principal cause of death and related causes of importance were as follows:
Influenza Meningitis Date of onset **1-10**

Other contributory causes of importance:
None

Name of operation **None** Date of.....
What test confirmed diagnosis **Clinical** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **No** 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 any way related to occupation of deceased?
If so, specify.....
(Signed) **Joseph Schulte** M. D.
ISOLATION HOSPITAL

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.

