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.

MAY 7 1937

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

Do not use this space.

File No. 14439

Registered No. 3935

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital No.1 St. ..... Ward)

σ 402

2. FULL NAME Charles Schoellhammer

(a) Residence, No. 1910 a Cherokee St., 24 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): Separated

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan 26, 1878

7. AGE: ~~60x~~ Years 59 Months 2 Days 17 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. machinist

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Garage

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) Germany

FATHER

13. NAME Gottfried Schoellhammer

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

MOTHER

15. MAIDEN NAME Mary ?

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

17. INFORMANT (ADDRESS) Hosp. Info. MH. Kent City Hospital No.1

18. BURIAL, CREMATION, OR REMOVAL PLACE New St. Marcus Cem. DATE April 16 1937

19. UNDERTAKER (ADDRESS) Ziegenhein Bros. 2623 Cherokee st

20. FILED APR 14 1937 19 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/13/37, 19

22. I HEREBY CERTIFY, That I attended deceased from 4/9/37, 19 to 4/13/37, 19

I last saw him alive on 4/13/37, 19 Death is said to have occurred on the date stated above, at 2.20 p m.

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

	Date of onset
Carcinoma of the larynx	Dec. 1936
Bronchopneumonia	Apr. 12, 37

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Findings Was there an autopsy? No

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) [illegible], M. D.

(Address) City Hospital No.1