

REC'D MAY 10 1938

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

12681

Do not use this space.

3285

1. PLACE OF DEATH

- (a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. .... Registered No. ....  
 (c) City St. Louis (d) Street No. En route City Hospital #1 St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? 54 yrs. - mos. - ds.

2. PRINT FULL NAME

- William Schmalzried 54.2.  
 (a) Residence, No. 4943 Lexington Ave. St. 6 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lucinda Schmalzried</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>August 26, 1870</u>		
7. AGE YEARS <u>67</u>	MONTHS <u>7</u>	DAYS <u>10</u>
IF LESS than 1 day, ..... hrs. or ..... min.		

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Milk Driver  
 9. Industry or business in which work was done, as saw mill, bank, etc. Dairy  
 10. Date deceased last worked at this occupation (month and year) 1931  
 11. Total time (years) spent in this occupation.....

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

FATHER

13. NAME Charles Schmalzried  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Mrs. Lucinda Schmalzried  
 (ADDRESS) 4943 Lexington Ave.

18. BURIAL PLACE St. Aetian Cemetery  
 (ADDRESS) April 9, 1938

19. FUNERAL DIRECTOR Wm. M. Schumacher  
 (ADDRESS) 4834 Natural Bridge

20. FILED APR 7, 1938  
J. T. Budick Local Registrar

MEDICAL STATEMENT OF OCCURRENCE

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/6/38, 19  
 22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to..... 19.....  
 I last saw him..... alive on..... 19..... P.M. Death is said to have occurred on the date stated above, at 9:14 a.m.  
 The principal cause of death and related causes of importance were as follows:

Hemorrhage due to linear fracture of skull; suffered in fall to sidewalk at southwest corner Kingshighway & Cabanne Ave., about 10:00 A.M. April 5th, 1938.

Other contributory causes of importance:  
186a

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Accident Date of injury 4/5/1938  
 Where did injury occur? St. Louis, Mo.  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
In Public Place  
 Manner of injury..... See Above.  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify.....  
 (Signed) Alfred Perry M.D.  
 (Address) Deputy Coroner

WRITE PLAINLY, WITH OMPACT, CONCISE STATEMENTS. 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.

1 X12004

STATEMENT BY LICENSED EMBALMER

I, John Ketter, Licensed Embalmer No. 3880  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by my self  
..... L. E. ....  
No. .... or by ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed John Ketter  
Licensed Embalmer No. 3880

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**