V. S. No. 2
100M—5-43
Rev. 5-17-39
1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4782

FILED FEB 24 1945

Registration District No. 318 Primary Registration District No. 1002 Registrar's No. 1066

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town ST. LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DEACONESS HOSP. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 HRS. (Specify whether
In this community LIFE years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 000 17
(c) City or town ST. LOUIS. 9 9
(If outside city or town limits, write "RURAL")
(d) Street No. 4329 COLLEGE AVE.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —0

3. (a) PRINT FULL NAME JOSEPH JAMES SCHALLERT

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex MALE 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE 0

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased SEPT. 18 — 1943
(Month) (Day) (Year)

8. AGE: Years 1 Months 4 Days 13 If less than one day hr. min.

9. Birthplace ST. LOUIS MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation CHILD

11. Industry or business —

FATHER
12. Name JOHN GERHARDT SCHALLERT
13. Birthplace ST. LOUIS MO 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MATILDA SCHMITZ
15. Birthplace ST. LOUIS MO. 0
(City, town, or county) (State or foreign country)

16. (a) Informant John J. Schallert
(b) Address 4329 College Ave.

17. (a) BURIAL (b) Date thereof FEB 2 = 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director Brockland and Co
(b) Address 1827 Hogan St.

19. (a) FEB 1 1945 (b) J. F. Bruecke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 31ST
year 1945 hour 7 20 minute A. M.

21. I hereby certify that I attended the deceased from Jan 30, 1945, to Jan 31, 1945
that I last saw him alive on Jan. 31, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death B. Pneumonia Primary — Duration 0

Due to —

Due to —

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy B. Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature [illegible] (M. D. or other) M.D.
Address [illegible] Date signed 1-31-45

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Albert D. Hoppe

Licensed Embalmer No. 1861

P. O. Address .....

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.)

If this body is not embalmed, fact should be so stated above: