

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

Do not use this space.

29578

1. PLACE OF DEATH

County Registration District No. 781
 Township Primary Registration District No. 208
 City St. Louis No. 5006 Plover Ave. St. Ward)

File No.
 Registered No. 8765

2. FULL NAME

David Schallert
 (a) Residence. No. 5006 Plover St. 7 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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 24 - 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at Home
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Francis Schallert

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Kelen Bruder

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

14. INFORMANT Francis Schallert
 (Address) 5006 Plover Street

15. FILED 19.....
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 27th 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug. 24th 1929, to Aug. 27th 1929, that I last saw him alive on Aug. 26th 1929, and that death occurred, on the date stated above, at 7:30A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congenital Atelectasis.

16 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 16 1/2 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. R. Newson M. D.

8/27. 1929 (Address) 5330 Geraldine Ave

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cem. DATE OF BURIAL Aug. 27, 1929.

20. UNDERTAKER Jos. W. Clark ADDRESS 1120 N. Locust Ave.

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.

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