

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.

JAN 24 1935

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

Do not use this space.

44733

## 1. PLACE OF DEATH

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. St. Anthony Hospital) - St. \_\_\_\_\_ Ward \_\_\_\_\_  
Registered No. 11859

## 2. FULL NAME

Infant of Elva E. & Florence Scholer  
(a) Residence, No. 7527 Washington St., N.R. Ward, St. Louis Co. Mo  
(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) See 15-1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
X X X or 30 min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant  
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) St. Louis Mo

FATHER 13. NAME Elva E. Scholer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis

MOTHER 15. MAIDEN NAME Florence Thomas

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

17. INFORMANT E. E. Scholer (ADDRESS) 7527 Washington

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE See 17 1934

19. UNDERTAKER Fitz Bros (ADDRESS) 3029 Lafayette St

20. FILED 20 10 1934 Registrar J. F. Bredeck

## 2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) See 15 1934

22. I HEREBY CERTIFY, That I attended deceased from See 15 1934, to See 15 1934

I last saw him alive on See 15 1934. Death is said to have occurred on the date stated above, at 10:45 P.M.

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

Abnormal presentation of infant for eyes 15/16 of after coming head  
16 1934  
Other contributory causes of importance: probable cerebral hemorrhage

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) Huston Bolonnen, M. D.

(Address) 2602 S. Grand St.

Dr. Johnson

2602 S. Grand