

FILED JAN 20 1945 518

Registration District No.

Primary Registration District No.

1003

Registrar's No.

199

1. PLACE OF DEATH:

(a) County _____
 (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:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution newborn
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
 (c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
 (d) Street No. 1237A So. VANDERVENTER
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ROBERT Baby Schulte (male)

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased NOV. 30 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name UNKNOWN

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name VIRGINIA SCHULTE

15. Birthplace ST. LOUIS MO. (U)
(City, town, or county) (State or foreign country)

16. (a) Informant VIRGINIA SCHULTE

(b) Address 1237A So. Vanderwerker

17. (a) Burial (b) Date thereof 1 9 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director W. H. Brock

(b) Address 2117 E. 11th

19. (a) JAN 9 1945 (b) J. J. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6th
 year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-30, 1944, to 1-6, 1945

that I last saw him alive on 1-6, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Epidemic Diarrhea of Newborn Duration 1 mo.

Due to _____

Due to _____

Other conditions: Prematurity
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy: None performed

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: C. J. Watkins (M. D. or other) M. D.

Address: 1515 Lafayette Date signed: 1/8/45

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

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.....

Licensed Embalmer No.....

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.