S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED OCT 27 1945

STANDARD CERTIFICATE OF DEATH

State File No. 34700

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 2947

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St Mary Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13. (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 0-0-0

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 7119 Alabama Ave 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME FREDERICK SCHELKER

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 Singel 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 10 (Day) 1945 (Year)

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

9. Birthplace St Louis County (City, town, or county) 0 (State or foreign country)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Fred Schelker
13. Birthplace MO. (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Marie Sommer
15. Birthplace MO. (City, town, or county) 0 (State or foreign country)

16. (a) Informant Fred Schelker
(b) Address 7119 Alabama

17. (a) (Burial, cremation, or removal) (b) Date thereof 10/23/45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Hope

18. (a) Signature of funeral director FENDLER UND CO.
(b) Address 7420 Michigan

19. (a) 10-24-45 (Date received local registrar) (b) E G McGarran MD (Registrar's signature) MSW

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21
year 1945 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from Oct 10, 1945, 19 to Oct 21, 1945;
that I last saw him alive on Oct 20, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	7 days
Due to Esophageal Atresia Congenital	13 days
Due to Tracheo-esophageal Congenital fistula	
Other conditions (Include pregnancy within 3 months of death) 157 mm	

Major findings:
Of operations
Of autopsy as above

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

23. Signature Jackson Eto (M. D. or other) M.D.
Address 6420 Clayton Rd Date signed 10/21/45

(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.....

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.

BURKHARDT GENERAL HOME
3300 STATE ST.
E. ST. LOUIS, ILL.