

No. 2  
739  
X-47070

FILED SEP 16 1946  
5888  
318

1003

Registration District No. 318

Primary Registration District No.

Registrar's No. 2724

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri.  
(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  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME JOHN J. SCHICHOFSKY

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 Single

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

7. Birth date of deceased June 10, 1886  
(Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days 5 If less than one day  
hr. min.

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

10. Usual occupation Laborer

11. Industry or business unk

12. Name unk

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

14. Maiden name unk

15. Birthplace unk  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Stettenhaus

(b) Address Delmar Hotel 71 Delmar

17. (a) MEMORIAL (b) Date thereof 9-9-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director J. J. Sullivan Bros

(b) Address 2849 N. Euclid

19. (a) SEP 8 1946 (b) J. J. Wredeck  
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. Ozma Shelter Home Memorial  
(If rural, give location) 3775 Monticony  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6th  
year 1946 hour 7:50 minute P M.  
21. I hereby certify that I attended the deceased from 8/14/46  
to Sept. 6th 19 46  
that I last saw him alive on Sept. 6th 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Carcinoma of Lung  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Hof  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

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) \_\_\_\_\_  
Date of occurrence \_\_\_\_\_  
(b) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(c) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature W. C. Beck (Specify type of place) \_\_\_\_\_  
Address 1515 LAFAYETTE Means of Injury \_\_\_\_\_  
Date signed 8/17/46

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.....

.....  
working under my personal supervision.

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

Signed.....

*Robert L. Bankman*

Licensed Embalmer No. 3503

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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 024Registration District No. 318Primary Registration District No. 1003Registrar's No. 7744

## 1. PLACE OF DEATH:

- (a) County.....  
 (b) City or town ST. LOUIS  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution..... (Specify whether

In this community.....  
years, months or days)3. (a) PRINT  
FULL NAMEJohn J. Schickofsky

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

4. Sex
- M
5. Color or race
- W
6. (a) Single, widowed, married, divorced
- S

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

7. Birth date of deceased.....
- 
- (Month) (Day) (Year)

8. AGE: Years Months Days Unless than one day
- 
- 60
- 3
- 3
- hr. min.

9. Birthplace.....
- 
- (City, town, or county) (State or foreign country)

10. Usual occupation
- laborer

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

15. Birthplace.....
- 
- (City, town, or county) (State or foreign country)

16. (a) Informant.....

- (b) Address.....

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

- (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

- (b) Address.....

19. (a) (Date received local registrar) (b)
- J. F. Brueck
- 
- (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....  
 (c) City or town.....  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.....  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- June
- Year
- 1946
- hour
- 10
- minute
- 15
- M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;

that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

- Due to.....

- Due to.....

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

- Major findings:
- 
- Of operations.....

- Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

32185