S. No. 2
I—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 18 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32973

Registrar's No. 8545

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Lukes Hospital
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Lukes Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County

(c) City or town Alton
(If outside city or town limits, write "RURAL")

(d) Street No. 605 Summit Ave.,
(If rural, give location)

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

N.R.

If yes, name country

3. (a) PRINT FULL NAME Infant; ALLEN SCHADE.

3. (b) If veteran, name war no

3. (c) Social Security No. 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 Sept. (Month) 3 (Day) 1947 (Year)

8. AGE: Years ---- Months --- Days 5 If less than one day ..... br. ..... min.

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

10. Usual occupation Infant.

11. Industry or business -----

FATHER
12. Name W.C.Schade,Jr.
13. Birthplace Cannonsburg, (City, town, or county) Pa. (State or foreign country)

MOTHER
14. Maiden name Florence Mary Allen.
15. Birthplace St. Louis, (City, town, or county) Mo. (State or foreign country)

16. (a) Informant W.C.Schade.
(b) Address 605 Summit Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director C.R.Lupton & Sons.,
(b) Address 7233 Delmar Blvd.,

19. (a) SEP 9 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8 year 1947 hour 1:40 minute P. M.

21. I hereby certify that I attended the deceased from date of birth, 19..., to ..., 19...; that I last saw him alive on Set 8, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis

Due to Prematurity (about 8½ wks)

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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 Maurice Lonsway (M. D. or other)

Address 3720 Washington Blvd Date signed 9/9/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

3720 Washington Blvd.,
JE-0300
1 to 3:30 P.M.

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 Clarence F. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, Mo.

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.