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

Do not use this space.

19758

File No. ____

Registered No. 5754

1. PLACE OF DEATH

County ____ Registration District No. 701

Township ____ Primary Registration District No. 1003

City St. Louis Mo. (No. 2002½ Gravois St. Ward)

2. FULL NAME Jacob Fred Schek.

(a) Residence. No. 2002½ Gravois St., 23 Ward. (If nonresident, give city or town and State)

(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-18-1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	68	4	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Meat Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): 12 yrs

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Fronton (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER August Schek

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Fred Schek

(Address) 2002½ Gravois

15. FILED ____ 19__ Max C Nordin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-18 1931

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__

that I last saw h____ alive on ____, 19__, and that death occurred, on the date stated above, at 7.30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries (Internal, Fracture of Pelvis) struck by auto in St. Louis, Mo. Deceased was a pedestrian (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) Accident (duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH ____

DID AN OPERATION PRECEDE DEATH? ____ DATE OF ____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? ____

(Signed) J. W. Cowan M.D.

5/19 1931 (Address) Dep. Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Doe Run Mo.	5-20 1931
20. UNDERTAKER	**ADDRESS**
McLaughlin	1631 Mo Ave.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD