

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

Do not use this space.

25781

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *City Hospital*)

File No. **0**

Registered No. **7386**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *1222 N. Market St.* Ward. *26*  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *None know*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*about 79*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Stitcher*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Germany*  
(STATE OR COUNTRY)

10. NAME OF FATHER *F. Schneider*

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

12. MAIDEN NAME OF MOTHER *None know*

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

14. INFORMANT *Marcel Starkoff*  
(Address) *City Hospital*

15. FILED *AUG 16 1927* *Marcel Starkoff* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 14 1927*

17. I HEREBY CERTIFY That I attended deceased from *Aug 9* to *Aug 14* that I last saw him alive on *Aug 14* and that death occurred, on the date stated above, at *5:10 PM*

THE CAUSE OF DEATH WAS AS FOLLOWS:  
*Chronic Myocarditis*  
*120* (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Senility*  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *90 B*  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *8*

WAS THERE AN AUTOPSY? *8*

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *Johannes* M. D.  
*8/15/27* (Address) *City Hospital*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Friedens* DATE OF BURIAL *Aug 17 1927*

20. UNDERTAKER *By Leidner Hud & N. Market* ADDRESS *1417*

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

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.

Shoreland