

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

Do not use this space.

28346

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township **St. Louis** Primary Registration District No. **1003**  
 City **St. Louis** (No. **1730** Mississippi St. Ward)

File No. **7859**  
 Registered No. **7859**

**2. FULL NAME**

(a) Residence. No. **1730** Mississippi St., **23** Ward.  
 (Usual place of abode) (If nonresident give city or town and State)  
 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 1 1927**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, **1** hr. or **15** min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Infant**  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**  
 (STATE OR COUNTRY)

10. NAME OF FATHER **Nickolas Schneider**

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

12. MAIDEN NAME OF MOTHER **Hazel Bayby**

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

14. INFORMANT **Nickolas Schneider**  
 (Address) **1730 Mississippi**

15. FILED **SEP -3 1927** **maur. Starkeoff**  
 19... Registrar

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 1 1927**

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at **5:30 A.** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**159** **Premature**  
 (duration) **1 hr** yrs. mos. ds.  
**Chill Cold** (duration) **1 hr** yrs. mos. ds.  
**CONTRIBUTORY (SECONDARY)** **Lived 1 hour**  
 (duration) yrs. mos. ds.

18. **1610** WHERE WAS DISEASE CONTRAILED **at home**  
 IF NOT AT PLACE OF DEATH. **no.** DID AN OPERATION PRECEDE DEATH. **no.** DATE OF **Sept 1-1927**

19. WAS THERE AN AUTOPSY? **no.** WHAT TEST CONFIRMED DIAGNOSIS? **no test**  
 (Signed) **Wm. Mahon**, M. D.

(Address) **2036 Lafayette**  
 \*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. **Premature labor**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **S.S. Peter & Paul** DATE OF BURIAL **9-3 1927**  
 20. UNDERTAKER **R. Schumacher** ADDRESS **3013**  
**Insurance**

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.

