

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

Do not use this space.

28606

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis* (No. of *Lutheran Hospital*)..... St. Ward)

2. FULL NAME

Lena Schmidt
 (a) Residence, No. *3918 Louisiana Ave* 16 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 *Female* | **4. COLOR OR RACE** *White* | **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** *(write the word)* *Divorced*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr. 16, 1902*
7. AGE YEARS *23* MONTHS *4* DAYS *26* If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT

Dora Schmidt
 (Address) *3918 Louisiana Ave*

15. FILED

SEP 13 1927
 REGISTRAR *Max C. Stanley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 12 1927*
17. I HEREBY CERTIFY That I attended deceased from *9/10/27* to *9/12/27* 19 *27* that I last saw deceased alive on *9/12/27* 19 *27* and that death occurred, on the date stated above, at *2 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

12 1/2 *Purulent Appendicitis*
 (duration) yrs. mos. *6* ds.
CONTRIBUTORY (SECONDARY) *Peritonitis*
acute toxic dilatation
 (duration) yrs. mos. *3* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF *9/7/27*
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS *Physician and*
(Signed) J. Hoffmeister, M.D.
9/13, 1927 (Address) *3915 85th St*

*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

New St. Marcus *Sept 15 1927*

20. UNDERTAKER

ADDRESS

Wacker-Helders *2331 S. Broadway*

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.

