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

28764

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 8305

Township ..... Primary Registration District No. 03 Registered No. .....

City St Louis (No. Deaconess Hospital St. ..... Ward)

2. FULL NAME Elisa Dorette Schnicke

(a) Residence. No. 2340 So. 11th 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Joseph J. Schnicke

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 10 - 1868

7. AGE: Years 59 | Months 4 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Hannibal
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Henry C Kleine
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Louise Tegtmeyer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Augusta C. Holmes
(Address) Portland Oregon

15. FILED SEP 13 1927 Henry C Starkloff REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1927, to Sept 16, 1927, that I last saw her alive on Sept 16, 1927, and that death occurred, on the date stated above, at 3 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis
Cerebral apoplexy
Embolism of lower end of Fascia ortery (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Hemiplegia - Gangrene of foot Non Diabetic (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Hemorhage Apoplexy
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) L. R. Hauptmann M.D.
9/17, 1927 (Address) 626 Chestnut Bldg

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Missouri Crematory
DATE OF BURIAL: 9-19-1927

20. UNDERTAKER: Witt Bros L&N Co 2929
ADDRESS: So Jefferson

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

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

PARENTS

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 .....
(Address)

15.
FILED ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(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?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,M. D

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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

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