

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. **4615**)

Varrelman Av

File No.....

35599

Registered No.....

10805

St.....

Ward.....

2. FULL NAME

(a) Residence. No. **4615 Varrelman Av. 15** 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.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Anton Schmitt

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

Oct 30 - 1873

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

54

1

2

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)

Housework

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St Louis

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Michael Zamboni

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT

(Address)

Anton Schmitt

4615 Varrelman Av.

15.

FILED

NOV - 2 1921

19

Max B Starkoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov. 30th 1927

17.

I HEREBY CERTIFY That I attended deceased from *Nov 30* *Oct 1* 1927 to *Oct 30* 1927 that I last saw h. ex. alive on *Nov 20* 1927, and that death occurred, on the date stated above, at *10:45 P.M.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Nephritis "toxic"

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Charles Anderson*

Charles Anderson, M. D.

, 19 (Address) *3105 S. Jefferson Ave*

*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

St Peter - Paul Church

Dec 3rd 1927

20. UNDERTAKER

ADDRESS

AM Gebren 2630 Grandis St

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.

3105 S. Jefferson