

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

Do not use this space.

39021

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. ....

Registered No. **11737**

St. .... Ward)

**2. FULL NAME**

*John Schaefer*

(a) Residence No. *3365 Manhattan at* St. **3** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred *32* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widower*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *Cora Estelle Schaefer*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 17, 1876*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ___ hrs. or ___ min.
	<i>51</i>	<i>7</i>	<i>12</i>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Day Laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer *Mr. L. J. Beef Co*

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

PARENTS

10. NAME OF FATHER *Jim Knab*

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

12. MAIDEN NAME OF MOTHER *Cora Riehl*

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

14. INFORMANT *Joseph W. Schaefer* (Address) *3365 Manhattan at*

15. FILED *9 30 1921* *Max G. Starkeoff* Registrar

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec. 29, 1927*

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..... *3 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Cellulitis of Right Arm & Hand*  
*15 3 9* (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Mammary Cancer*  
*Not Ascertained* (duration) yrs. mos. da.

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) *P. S. Via* M-D  
*12/30, 1927* (Address) *Coroner Co.*

\*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 *Lakewood Park Land* DATE OF BURIAL *Dec 31 1927*

20. UNDERTAKER *Kueghauer & Co* ADDRESS *4109*

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.

