

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

Do not use this space.

3244

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo. (No. 3603rd Sossuth Ave) St. _____ Ward _____

File No. _____
 Registered No. 868

2. FULL NAME

William H. Schriefer
 (a) Residence. No. 3603rd Sossuth Ave St. 10 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 Male 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 Anna C. Schriefer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14 - 1855

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	72	9	8	

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

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

PARENTS

10. NAME OF FATHER Ernest H. Schriefer
 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) Don't know

14. INFORMANT Anna C. Schriefer
 (Address) 3603rd Sossuth Ave.

15. FILED 2-1 1928 May 6 Start off
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 22 19 28

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1928, to Jan 21, 1928
 that I last saw him alive on Jan 21, 1928, and that death occurred, on the date stated above, at 12:28 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108 (duration) yrs. mos. 5 ds.
 CONTRIBUTORY (SECONDARY) 101 W (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH. No DATE OF _____
 WAS THERE AN AUTOPSY. No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) C Klein Schmidt, M. D.
1/29, 1928 (Address) 626 Metairie Plaz

*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 Western Lutheran DATE OF BURIAL Jan 24 19 28

20. UNDERTAKER Hy Leidner 1417 N. Market St. ADDRESS 1417

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.

