

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

Do not use this space.

19404

1. PLACE OF DEATH

County.....
Township.....
City St. Louis

Registration District No. 791
Primary Registration District No. 1003
No. Christian Hospital

File No.....
Registered No. 5845
St..... Ward.....

2. FULL NAME Marianne Schild

(a) Residence No. 4339 Olive St. St. 19 Ward.....
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | White | Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 29m 1842

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	86	1	0	

8. OCCUPATION OF DECEASED

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

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

12. MAIDEN NAME OF MOTHER Marie Scoll,

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

14. INFORMANT Miss Elsie Schild
(Address) 4339 Olive St.

15. FILED 31 1927 Max E. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 19 28

17. I HEREBY CERTIFY, That I attended deceased from May 17th, 1928, to May 29, 1928, that I last saw her alive on May 29, 1928, and that death occurred, on the date stated above, at 2 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Chronic Myocarditis
110 General Atherosclerosis
97 Chronic Interstitial hepatitis
(duration) 10 yrs. mos. da.

CONTRIBUTORY (SECONDARY) 129
(duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory - clinical
(Signed) E. Eugene Brown, M. D.
, 19 (Address) 4348 Olive 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 Bellefontaine DATE OF BURIAL May 31 19 28

20. UMBERTAKER Geo. L. Peitach ADDRESS 5966 Easton

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.

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

1st of 1900
1st of 1900
1st of 1900

2-