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

Do not use this space.
3849

1. PLACE OF DEATH

County..... Registration District No. 791

Township St. Louis Primary Registration District No. 1003

City St. Louis (No. 4150, Glasgow Ave St., ... Ward)

File No. ..... Registered No. 457

2. FULL NAME Lena Schmidt

(a) Residence. No. 4150 Glasgow Ave St., 20 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)
Female	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Max Schmidt

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
abt 47				

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) St. Louis Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER William Strumpfer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Lena Basil
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Max Schmidt
(Address) 4150 Glasgow Ave

15. FILED ..... 19..... Mr. Gilbertson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 8 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1926, to Jan 8, 1929 that I last saw h. alive on Jan 5 1929, and that death occurred, on the date stated above, at 1:50 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 50

LC

Carcinoma of lung (Metastasis) (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Radical breast amputation (Rt.) Jan 5-1927 (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? no
WHAT TEST CONFIRMED DIAGNOSIS? X-ray + clinical finding

JAN 8 1929 (Signed) Albert J. Moser M.D
(Address) 208-9 LINDELL TRUST BLDG.
2743 NORTH GRAND BLVD.

*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
Friedens	Jan 11 1929

20. UNDERTAKER	ADDRESS
Math. Hermann & Son	2161 E. Fair Ave

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 INDELIBLE INK—THIS IS A PERMANENT RECORD

23-5
-1
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-0
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