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

Do not use this space.

4371

File No. .....
Registered No. 1001

1. PLACE OF DEATH
County St. Louis Mo
Registration District No. 2 791
Township ..... Primary Registration District No. 10083
City ..... (No. ..... St. ..... Ward)
St. Louis City Infirmary

2. FULL NAME Andrew Schmidt
(a) Residence. No. St. City Infirmary St., 13 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 Lizzie Schmidt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 14, 1850

7. AGE: Years 78 | Months 3 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER ?
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ? (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ? (STATE OR COUNTRY)

14. INFORMANT Howard Griffith
(Address) City Infirmary

15. FILED 2 1 1929 Walter C. Werlesy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/20 1929

17. I HEREBY CERTIFY, That I attended deceased from Chronic 19 ..... 19 28 to Jan 20 19 29 that I last saw h. alive on Jan 20 1929, and that death occurred, on the date stated above, at 5 30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
195

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Unknown
Did an operation precede death? No. Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical & physical exam
(Signed) Virgil C. Tank M. D
1/20, 1929 (Address) City Infirmary

*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 Calvary
DATE OF BURIAL 1/22 1929

20. UNDERTAKER J P Murrello Sons
ADDRESS 1407 Murphy 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.

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

262 10 31 21 78 3 6