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

Do not use this space.

8460

File No. 791 1003

Registered No. 2126

**1. PLACE OF DEATH**

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

City St. Louis Mo. (No. 5600, Arsenal St. ..... Ward)

**2. FULL NAME** Clifford W. Schmidt

(a) Residence. No. 5603 Michigan St., 15 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 5 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) |
|---|---|---|
| Male | White | Single |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 9, 1920

| 7. AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 8 | 4 | 5 | |

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

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

PARENTS

10. NAME OF FATHER George Schmidt

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

12. MAIDEN NAME OF MOTHER Anna Kirkpatrick

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

14. INFORMANT Loraine Kroner
(Address) 5600 Arsenal St.

15. FEB 15 1929 FILED Nat C. Starkloff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/14 1929

17. I HEREBY CERTIFY, That I attended deceased from 2/7, 1929, to 2/14, 1929 that I last saw h. alive on 2/14, 1929, and that death occurred, on the date stated above, at 9.28 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diphtheria Pharyngeal. 10
Myocarditis, Acute. 93 A
(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 5603 Michigan

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Culture

(Signed) Curtis H. Pohlmann, M. D.

2/15, 1929 (Address) 5600 Arsenal 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 S.S. Peter & Paul — DATE OF BURIAL 2/18 1929

20. UNDERTAKER Hoffmeister U.&E. Co. — ADDRESS 7814 S. Broadway

NOTE: Full name of informant 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.