

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

Do not use this space.

12582

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City *St. Louis* (No. *Seacress Hospital*)

File No.....

Registered No.....

3110

St.....

Ward)

2. FULL NAME

Annie Schumann

(a) Residence. No. *1502 So. 12th* St., *23* Ward.

(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

Female

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

William Schumann

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

Dec. 9, 1863

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

65

3

1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife

(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)

Missouri

10. NAME OF FATHER

Valentine Wahn

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT

M. Schumann
(Address) *1502 So. 12th Str.*

15.

FILED

12 1229
May C. Parker

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 10th 1929*

17.

I HEREBY CERTIFY, That I attended deceased from *March 4, 1929*, to *March 10, 1929* that I last saw him alive on *March 10, 1929*, and that death occurred, on the date stated above, at *11 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

930

CONTRIBUTORY (SECONDARY)

9000

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, *1502 So. 12th St. St. Louis*

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *General physical - X ray*

(Signed) *A. R. Shifflet*, M. D.

3/12, 1929 (Address) *1021 Missouri Bldg.*

*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

Bellefontaine Cem Mar. 13 1929

20. UNDERTAKER

ADDRESS

Witt Bros L & Co 2929 So Jefferson

X. 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.

1-23-29

