

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

Do not use this space.

35398

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City of St. Louis**)

File No.....
Registered No. **10141**
St. Ward)

2. FULL NAME

(a) Residence. No. **4728 Varelmann** 15. Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred **37** yrs. mes. 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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 6 - 1899**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 4 8

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

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

10. NAME OF FATHER **P. S. Schmidt**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Missouri**

12. MAIDEN NAME OF MOTHER **Johanna Zehnbauer**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Missouri**

14. INFORMANT (Address) **City of St. Louis**

15. FILED **76 1229** **Mar E. Starnes** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 14 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 12**, 19**29**, to **Oct 14**, 19**29**, that I last saw him alive on **Oct 14**, 19**29**, and that death occurred, on the date stated above, at **4:17 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy
131
32 (duration) yrs. mos. **3** ds.

CONTRIBUTORY (SECONDARY) **Ch. Int. Nephritis** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **1290 W. ...**
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **10/15/29**
WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS **R Berg**
(Signed) **10/15/29** (Address) **City Hospital** M. D.

*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 **St Peter - Paul County** DATE OF BURIAL **Oct 16 1929**

20. UNDERTAKER **J. H. Ebbken 2630 Crovois Ave** ADDRESS

K. 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.

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

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Schmidt