

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

Do not use this space.

17432

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **2322**)

St. **Compton** Ward

File No.....

Registered No. **4500**

**2. FULL NAME**

(a) Residence. No. **2322** **Compton** **St. 17** 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)

**Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 19 - 1869**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

**60**

**7**

**15**

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)

(STATE OR COUNTRY)

**Germany**

10. NAME OF FATHER **FRANZ. SCHIMMELPFENNIG**

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

(Address)

**Louis F. Rumpf  
5002 Kingshighway SW**

15.

FILED

May 19

**Max C. Stanley**

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 4 1930**

17. I HEREBY CERTIFY, That I attended deceased from **May 3 1930**, to **May 4 1930** that I last saw him alive on **May 4 1930** and that death occurred, on the date stated above, at **15 m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Carcinoma of Liver  
40 F  
12 h**

CONTRIBUTORY (SECONDARY) **Cholerae typhosa**

18. WHERE WAS DISEASE CONTRACTED

**NOT AT PLACE OF DEATH**

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

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **W. A. Scott** M. D.

**May 4, 1930** (Address) **3548 So. Juniper**

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

**St Peter Paul**

**May 7 1930**

20. UNDERTAKER

ADDRESS

**Wacker-Helderle**

**2331-S Bldg**

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.

1833

1833