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

Do not use this space.

17733

1. PLACE OF DEATH
County ..... Registration District No. 791 ~~1003~~ File No. .....
Township ..... Primary Registration District No. ..... Registered No. 4831
City St. Louis Mo (No. 4032 Schreve ave St. ..... Ward)

2. FULL NAME Jacqueline Schaeffer
(a) Residence. No. 4032 Schreve St., 7 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) —

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 7 - 1929

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	5	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home 1791
(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 John J Schaeffer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Mamie Wilmes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bowling Green
(STATE OR COUNTRY) Mo

14. INFORMANT John J. Schaeffer
(Address) 4032 Schreve Ave

15. FILED MAY 17 1930 19 Max C Hankey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. No Physician in attendance.
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 5:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cyanide Poisoning received while sleeping in room which was recently fumigated
(duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) John J Hurley M.D.
5/16, 1930 (Address) Deputy Coroner

*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 Cemetery
DATE OF BURIAL 5/19/30

20. UNDERTAKER Frost & Carroll
ADDRESS 4600 Natt Bridge

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

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.