

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

Do not use this space.

28346

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townshp..... Primary Registration District No. **1003**
 City **St Louis** (No. **6020 Michigan Ave**)

File No.....
 Registered No. **8201**
 St. Ward)

2. FULL NAME Peter A Schmoll

(a) Residence. No. **6020 Michigan Ave** St. **1** 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 **Male** 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 **Amelia Schmoll**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 25, 1866**

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, hrs. or min.
	63	9	21	

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

9. BIRTHPLACE (CITY OR TOWN) **Holland**
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER **Gerrit Schmoll**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Holland**
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER **Fredrica BonLonner**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Holland**
 (STATE OR COUNTRY)

14. INFORMANT **Amelia Schmoll**
 (Address) **6020 Michigan**

15. **AUG 18 1930** FILED **19** **Mrs C Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. HEREBY CERTIFY, That I attended deceased from **Aug 15**, 19**30**, to **Aug 16**, 19**30**, that I last saw him alive on **Aug 15**, 19**30**, and that death occurred, on the date stated above, at **5:30 A** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

angina pectoris
59
74A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **heraldic heart** (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) **W. M. ...** M. D.

8/16 19**30** (Address) **6847 Uia**

*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 Trinity Luth Cem** DATE OF BURIAL **Aug 19 30**
 19

20. UNDERTAKER **Thos. H. Biederwiden** ADDRESS **1936 St Louis**

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.

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

