

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

Do not use this space.

37605

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis. (No. 4800 Eichelberger Street. St. Ward)

File No.
 Registered No. 10688

2. FULL NAME Louis Schmidt.

(a) Residence No. 4800 Eichelberger St., 2 Ward. (If nonresident, give city or town and State)
 (Usual place of abode)

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** Married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 18, 1860.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 70 11 22.

B. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Jeweler.
 (b) General nature of industry, business, or establishment in which employed (or employer) Retired 18 years.
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Germany.
 (STATE OR COUNTRY)

10. NAME OF FATHER Jacob Schmidt.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany.
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sophia Brinkmann.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany.
 (STATE OR COUNTRY)

14. INFORMANT Maria Schmidt
 (Address) 4800 Eichelberger Street.

15. FILED 12 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov-10-1930

17. I HEREBY CERTIFY, That I attended deceased from November 28, 1930, to Nov 10, 1930, and that I last saw him alive on Nov 9, 1930, and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS

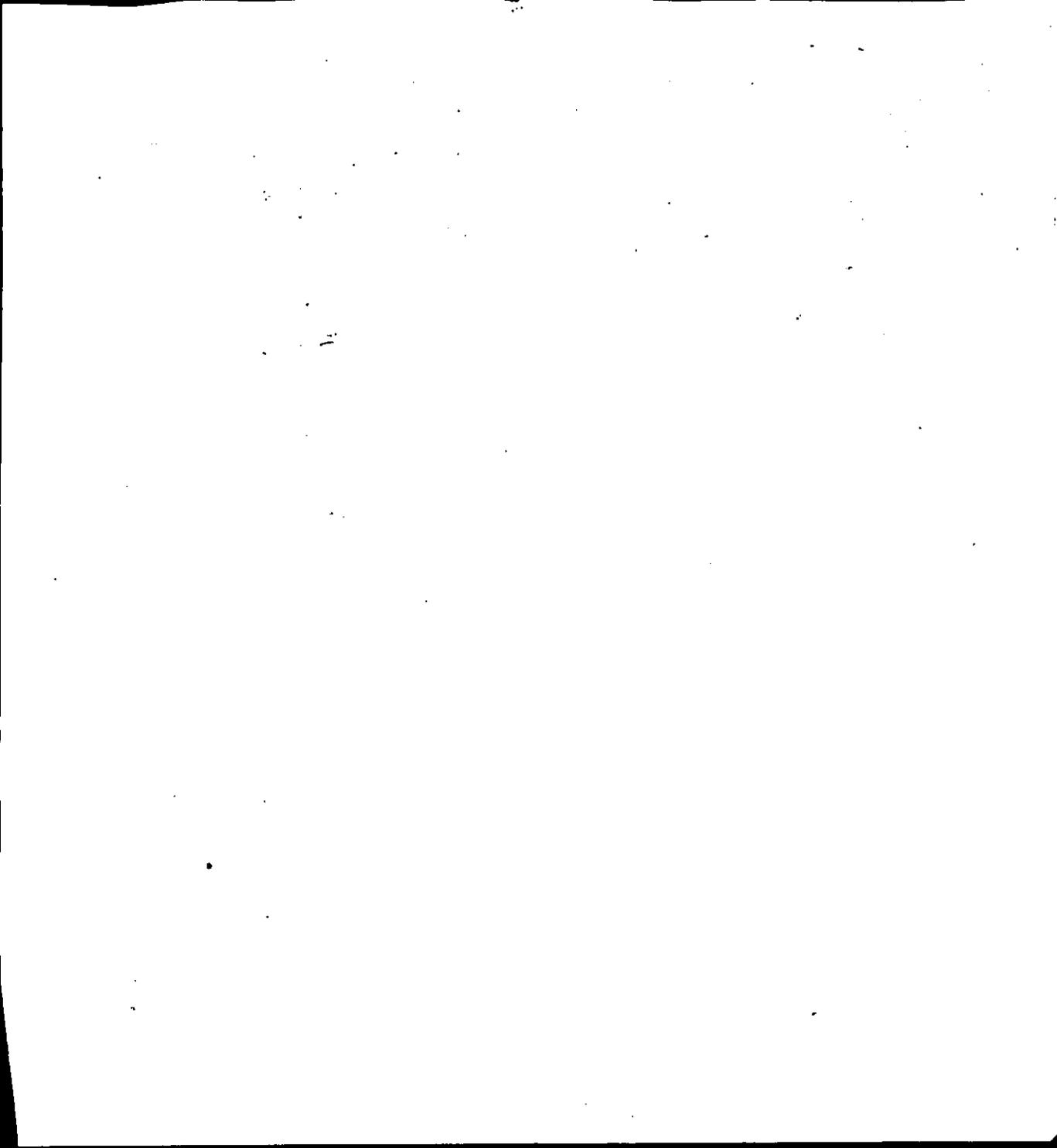
Carcinoma of Lung 11:30 A.M.
 (duration) yrs. mo. ds.
CONTRIBUTORY (SECONDARY)
 ① nephritis chronic interst. (duration) yrs. mo. ds.
 ② diabetes mellitus (2 yrs) (37)
 ③ Carcinoma of liver (17 mos) (37)

18. WHERE WAS DISEASE CONTRACTED U.S.A.
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Laboratory
 (Signed) J. M. Horvath, M. D.
Nov 11, 1930 (Address) 5005 a grand

*State the DISEASE CAUSING DEATH, or in death 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** Nov. 13, 1930.

20. UNDERTAKER J. V. Gebbler & Co. **ADDRESS** 2842 Meramec



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 791 File No.
 Township..... Primary Registration District No. 1003 Registered No. 10688
 City St. Louis (No.) St. Ward

2. FULL NAME Louis Schmidt

(a) Residence. No. St., 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18-1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 11 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration)..... yrs. mos. ds.
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED JAN - 7 1931 Wm O Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 1930

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... (that I last saw him alive on) 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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