

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

Do not use this space.

7996

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

File No.

Township.....

Primary Registration District No.

Registered No. **2367**

City *St. Louis, Mo.* (No. *4024 Grove*)

St. Ward)

2. FULL NAME *Adolph J. Schmidt*

(a) Residence. No. *4024 Grove* St. *10* 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. da.

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 *Emma Schmidt*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 28 - 1886*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 11 22

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *Printer 55*
(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) *Mo 1*

PARENTS
10. NAME OF FATHER *Christ Schmidt*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany 10*
12. MAIDEN NAME OF MOTHER *Catherine Stindler*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

14. INFORMANT *Emma Schmidt* (Address) *4024 Grove St.*

15. FILED: *22 1931* *Way & Warden* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2/20/31* 19*31*

17. I HEREBY CERTIFY, That I attended deceased from *Feb. 19*, 19*31*, to *Feb 20*, 19*31*, that I last saw *him* alive on *Feb 20*, 19*31*, and that death occurred, on the date stated above, at *5:30 p.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Double lobar Pneumonia

(duration) yrs. mos. *3* ds.

CONTRIBUTORY (SECONDARY) *108* (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? *0*

WHAT TEST CONFIRMED DIAGNOSIS? *2/20/31* (Signature) *W. H. ...*, M. D. *122*, 19*31* (Address) *1901 Madison*

*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. Johns North* DATE OF BURIAL *Feb 24 19 31*

20. UNDERTAKER *W. J. Leidner and Co. St. Market* ADDRESS *1417*

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.

