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

Do not use this space.

12300

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. ~~1930 O Fallon St~~ ..... St. ..... Ward)

File No. .....

Registered No. 3564

2. FULL NAME Michael Gschwender

(a) Residence. No. 5011 Durant ave 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 13. 1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
55	~~[illegible]~~	~~[illegible]~~ 5	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tuc Pointer 95
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer A. Weber

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY) 13

PARENTS

10. NAME OF FATHER Michael Gschwender

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

12. MAIDEN NAME OF MOTHER do not Know

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

14. INFORMANT Kate Gschwender
(Address) 5011 Durant ave

15. FILED MAR 23 1931 Max C Parker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/21/31 19

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 1-20 P m.

165 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Strangulation due to hanging by rope at 1930 O Fallon St (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF 7
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) [signature] ~~M.D.~~
3/23, 1931 (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	DATE OF BURIAL
Calvary Cemetery	3/24 1931
20. UNDERTAKER	**ADDRESS**
Henry Lerdner Und Co	2223 St Louis ave

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.