

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

Do not use this space.

19352

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis Mo.

(No. Morganford-Neosho Sts.)

File No.

Registered No. 5295

St. Ward

2. FULL NAME Edward Schafnitz
4739 Morganford

(a) Residence. No. St. 15 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 Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 3rd 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 8 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheet Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Western Sheet Metal
(c) Name of employer

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

10. NAME OF FATHER Nichols Schafnitz

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

12. MAIDEN NAME OF MOTHER Thresa Frohmm

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

14. INFORMANT Anna Schafnitz
(Address) 4739 Morganford

15. FILED 5 1 1935 New Orleans REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2nd 1931

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..... 2: P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Fractured Skull & Neck by Auto while working in Street in St. Louis
CONTRIBUTORY Accident
(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? yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. M. Kerner M.D.
54 19 31 (Address) Dep. Comm.

*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 Sun Set Burial Park DATE OF BURIAL 5-5-1931

20. UNDERTAKER Hacker & Helder ADDRESS 2331 S. Broadway

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.

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