

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

Do not use this space.

20947

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **City Hospital**)

File No.....
 Registered No. **5443**
 St..... Ward)

2. FULL NAME

(a) Residence, No. **4445 Newsham** St. **15** Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred **40** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 14-1891**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	40	11	22	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Laborer**
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **2-37**
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Mo.**

13. NAME **Gus Schwalb**

14. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Mo.**

15. MAIDEN NAME **Minnie Steinmetz**

16. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Mo.**

17. INFORMANT (ADDRESS) **Hospital information**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Lebros Hospital** DATE **6-8** 1927

19. UNDERTAKER (ADDRESS) **Schumacher 3013**

20. FILED **JUN - 7 1927** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **June 5th, 1932**

22. I HEREBY CERTIFY, that I attended deceased from **April 21st** 19**32**, to **June 5th** 19**32**
 I last saw him alive on **June 5th** 19**32** Death is said to have occurred on the date stated above, at **5:53 P.M.**
 The principal cause of death and related causes of importance were as follows:

1. **Pernicious Anemia**
 2. **lobar Pneumonia**
 3. **Urinary Retention**

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis? **Clen** Was there an autopsy? **h**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19**32**
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....
 (Signed) **Raymond R. Faub** M. D.
 (Address) **City Hospital**

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.

Schwab-