

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

Do not use this space.

42668

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. 5765 Cabanne)..... St. Ward.....

File No.....
Registered No. 6
St. Ward.....

2. FULL NAME

(a) Residence, No. 5765 Cabanne St. 12 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 28-1847
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 2

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

12. BIRTHPLACE (CITY OR TOWN) Cabanne (STATE OR COUNTRY) Mo.

13. NAME John Schilder

14. BIRTHPLACE (CITY OR TOWN) unk (STATE OR COUNTRY)

15. MAIDEN NAME unk

16. BIRTHPLACE (CITY OR TOWN) unk (STATE OR COUNTRY)

17. INFORMANT A. J. C. Heinrichs (ADDRESS) 4518 Findeell Blvd

18. BURIAL, CREMATION, OR REMOVAL PLACE Grainfield DATE Jan 2 1923

19. UNDERTAKER (ADDRESS) H. A. Shields Grainfield

20. FILED Jan 1 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) See 30, 1932

22. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1932, to Dec. 30, 1932
I last saw him alive on Dec. 30, 1932. Death is said to have occurred on the date stated above, at 7:40 p.m.
The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia

Date of onset 12/20/32

Other contributory causes of importance: Cardio Renal Vascular Disease

1922

Name of operation None. Date of.....

What test confirmed diagnosis? None. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

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) F. C. Rosell, M. D.
(Address) 3945 N. 11th

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.

