

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

Do not use this space.

15254

1. PLACE OF DEATH

County.....

Registration District No. **791
1003**

Township.....

Primary Registration District No.

City *St. Louis Mo.* (No. *2105 St. 10th St.*)

File No.

Registered No. **3795**

St. Ward)

2. FULL NAME *Margaret Schmeisser*

(a) Residence, No. *2105 St. 10th St.* St. *26* 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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 6th 1856*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

83

3

19

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Housework

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) (STATE OR COUNTRY) *Mo.*

MOTHER FATHER

13. NAME *Charles Hartenstein*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

15. MAIDEN NAME *Not known*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT *Charles Schmeisser*

(ADDRESS) *2105 St. 10th St.*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Bethania*

DATE *April 28*, 19*33*

19. UNDERTAKER *Hy Leidner*

(ADDRESS) *1417 St. Mark St.*

20. FILED **APR 27 1933**

19

Max O. Hardung

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 25th*, 19*33*

22. I HEREBY CERTIFY, That I attended deceased from *January 8*, 19*33*, to *April 25*, 19*33*

I last saw her alive on *April 23*, 19*33*. Death is said to have occurred on the date stated above, at *8th P. m.*

The principal cause of death and related causes of importance were as follows:

*cerebral haemorrhage
non (apoplexy)*

Date of onset

January 8/33

Other contributory causes of importance: *J.S.W.*

Name of operation.....

Date of.....

What test confirmed diagnosis?.....

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? *No*

If so, specify

(Signed) *George Mueller*, M. D.

(Address) *1502 St. Louis*

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.

1. [Illegible text]

2. [Illegible text]

3. [Illegible text]

4. [Illegible text]

5. [Illegible text]

6. [Illegible text]

7. [Illegible text]

8. [Illegible text]

9. [Illegible text]

10. [Illegible text]

11. [Illegible text]

12. [Illegible text]

13. [Illegible text]

14. [Illegible text]

15. [Illegible text]

16. [Illegible text]

17. [Illegible text]

18. [Illegible text]

19. [Illegible text]

20. [Illegible text]