

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.

SEP 26 1933

Je 1830 Riv 2580

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

Do not use this space.

27927

1. PLACE OF DEATH

County *Jackson Hoop*
Township *369 So. Euclid*
City *(No)*

Registration District No. *791*
Primary Registration District No. *1003*

File No. *6977*
Registered No. *6977*
St. _____ Ward _____

2. FULL NAME

Marie Rose Gschwend Gschwend

(a) Residence, No. *4421 Bingham* St. *15* 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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 19, 1918*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
15 4 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as planner, Sawyer, bookkeeper, etc. *at home*
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) *St Louis Mo*

MOTHER FATHER 13. NAME *Henry Gschwend*

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

15. MAIDEN NAME *Anna Walz*

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

17. INFORMANT *Hy Gschwend* (ADDRESS) *4421 Bingham*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Ignace* DATE *8/14/33*

19. UNDERTAKER *J. J. Ziegenhagen & Son* (ADDRESS) *1702 Jefferson*

20. FILED *AUG 12 1933* *J. F. Bredeck* Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 11-1933*

22. I HEREBY CERTIFY, That I attended deceased from *8-2-1933*, to *8-11-1933*, 19*33*. I last saw h. P. alive on *8-11-1933* Death is said

to have occurred on the date stated above, at *9:45 A.* m. The principal cause of death and related causes of importance were as follows:

Purpura thrombotica
87
Other contributory causes of importance:
Central thrombosis

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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) *Carl J. Kern* M. D.
(Address) *5243 E. 8. Grand*

