

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City St. Louis mo

(No. Barnes Hospital)

791
1003

File No. 11089
Registered No. 2949
St. Ward)

2. FULL NAME

Ruth Sittom Schierbaum

(a) Residence, No. 4462 Forest Park St. 19 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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Gerard D. Schierbaum</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 21 - 1910</u>				
7. AGE	YEARS <u>23</u>	MONTHS <u>11</u>	DAYS <u>-</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spliner, sawyer, bookkeeper, etc. <u>Housewife</u>			
	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	

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-24-1934
22. I HEREBY CERTIFY, That I attended deceased from 3-9-1934 to 3-24-1934
I last saw her alive on 3-21-1934 Death is said to have occurred on the date stated above, at 11:45 PM.

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

Peritonitis, post-operative
Septicemia
Meningitis

Date of onset

Other contributory causes of importance
79A

Name of operation Excision of Uterus
Appendectomy Date of 3/10/34
What test confirmed diagnosis? Bl. culture 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

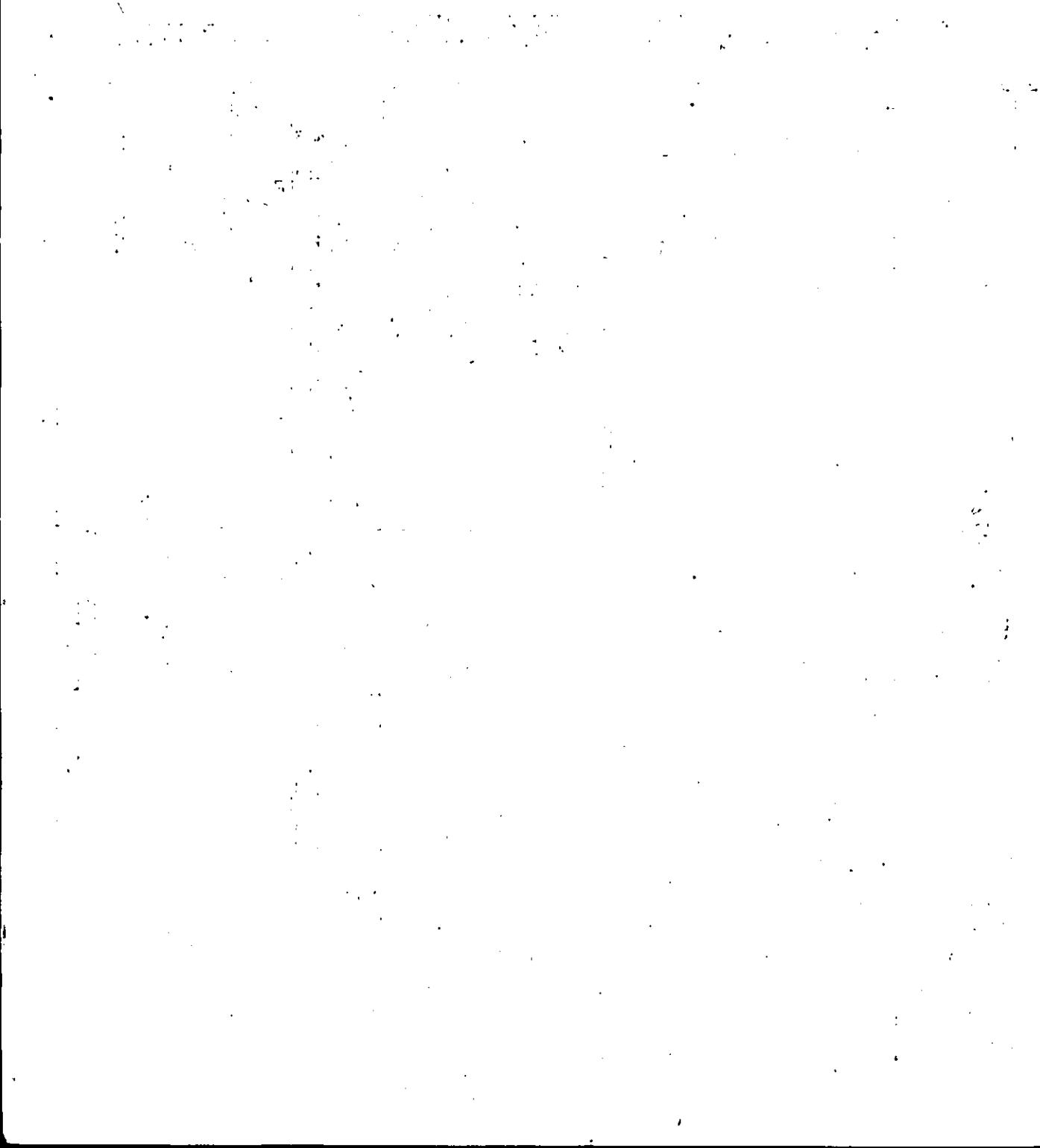
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) A. J. Keene, M. D.

(Address) 600 S. Kingshighway

APR 25 1934

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.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
13. NAME William N. Sutton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
15. MAIDEN NAME Hannah Brenker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
17. INFORMANT Gerard D. Schierbaum
(ADDRESS) 4462 Forest Park Blvd
18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cem DATE Mar 24 1934
19. UNDERTAKER W. J. Miller Undertaking Co
(ADDRESS) 516 S. Delmar Blvd
20. FILED 104 24 1934
Registrar.



Gentlemen —

10/9/34

This was a post-operative,
not a puerperal case.

Pt. had chronic appendicitis
at time of operation.

Meningitis was a terminal
affair — part of the
general streptococcal
septicemia — therefore it
was a streptococcal
meningitis.

J. H. Klein, M.D.

680:1-1035

6291

St Louis City

WASHINGTON *2949*

11089

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Ruth S. Scherbaum*
Who died at *Barnes Hosp* on *Mar 21-1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *F* Color or race *w* Single, married, widowed or divorced: *m*

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: *Bronchitis, post operative-septicemia, meningitis*

Other contributory causes of importance _____

Name of operation *suppression of uterus* Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

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

If so, specify _____

Name of physician *H. J. Klieser*

Address of physician *690 S. Kings highway*

Signature of Registrar *J. F. Bedeck* Date filed *Oct 10-34*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *791*

Primary Reg. Dist. No. *1003*

Very truly yours,
E. T. McLaugh
Special Agent.

