

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

Do not use this space.

JUN 12 1935

18456 ✓  
4810

1. PLACE OF DEATH

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City *St. Louis* (No. of *St. Anthony's Hosp*)..... Ward.....

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

2. FULL NAME

*Susan Katherine Schmitt*  
(a) Residence, No. *5415 Alvarado* St., *14* 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 <i>Female</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Joseph Max Schmitt</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>March 27, 1863</i>		
7. AGE YEARS <i>72</i>	MONTHS <i>2</i>	DAYS <i>4</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housework</i>		
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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-31-1935*

22. I HEREBY CERTIFY, That I attended deceased from *May 29* - 1935, to *May 31*, 1935  
I last saw *her* alive on *May 31*, 1935 Death is said to have occurred on the date stated above, at *11:00 A.M.*

The principal cause of death and related causes of importance were as follows:  
*Cholecystitis, Chylothorax, Myocarditis, etc.*

Date of onset *7-22-34*

Other contributory causes of importance: *930*

Name of operation *none* Date of operation *labatory*  
What test confirmed diagnosis? *Physical* 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) *Robert G. Warner*, M. D.  
(Address) *1020 Paul Brown Bldg St. Louis 20*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*

MOTHER FATHER

13. NAME *Geo. A. East*

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

15. MAIDEN NAME *Susan Seufre*

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

17. INFORMANT *Joseph M. Schmitt*  
(ADDRESS) *5415 Alvarado*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *St. Peter's Ch. St. Louis* DATE *6-3-35*

19. UNDERTAKER *Joseph M. Schmitt*  
(ADDRESS) *43318 St. Louis*

20. FILED *31* 1935 19.....  
Registrar

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 4810  
St. .... Ward)

**2. FULL NAME**

Susan Katherine Schmitt

(a) Residence, No. .... St. .... 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 F | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED JK  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
72 | 2 | 4

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

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 6/19 1955 J. F. Prudeck Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-31-1935

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to 19...  
I last saw h. .... alive on 19... Death is said to have occurred on the date stated above, at.....m.

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

Date of onset

Other contributory causes of importance:

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?.....  
If so, specify.....

(Signed)....., M. D.

(Address).....

**SUPPLEMENTARY**

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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