

AUG 9 1935

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. 791

Township.....

Primary Registration District No. 1003

City, *St. Louis* (No. *45207*)City *St. Louis*

File No. 24774

Registered No. 6206

St. Ward)

2. FULL NAME

(a) Residence, No. *708*
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M*4. COLOR OR RACE *W*5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John Schimmer*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 19 - 1894*7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
*41 2 0*8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Work*

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) *Austria*13. NAME *Paul Kusin*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*15. MAIDEN NAME *Theresa Klaut*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*17. INFORMANT *Walter J. ...*
(ADDRESS) *St. Louis*

18. BURIAL, CREMATION OR REMOVAL

PLACE *St. Peter's* DATE *July 29 1935*19. UNDERTAKER *Wacker-Heiderle*
(ADDRESS) *2331 St. Bernard*20. FILED *20* 1935, 19 *J. F. Brudick*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 19, 1935*22. I HEREBY CERTIFY That I attended deceased from *7/15*, 19*35*, to *July 19*, 19*35*.I stated when alive on *7/19*, 19*35*. Death is saidto have occurred on the date stated above, at *6* p.m.

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

*Pulmonary T. B.**Tuberculosis meningitis*Other contributory causes of importance: *23*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? *Yes*

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) *T. J. ...*, M. D.(Address) *City, Mo.*

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.

