

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.

1938

DEC 8 1938

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

40276  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784E  
 (b) Township Central Primary Registration District No. 101  
 (c) City Clayton (d) Street No. St. Louis County Hospital Registered No. 1861  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: 535 Theresa Schmieding  
 (a) Residence, No. 6450 Ridge Ave. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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 Henry C. Schmieding

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 24 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hr. or .....min.  
73 8 20

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework.  
 9. Industry or business in which work was done, as saw mill, bank, etc. At home  
 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) Cincinnati, Ohio

FATHER  
 13. NAME Joseph Niesing  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mass.

MOTHER  
 15. MAIDEN NAME Theresa Kirst  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alsace Lorraine

17. INFORMANT (ADDRESS) Mrs Julia Meyer  
6450 Ridge Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE Nov. 16 1938

19. FUNERAL DIRECTOR (ADDRESS) Jos. W. Clark  
1125 Hadjiamont Ave

20. FILED NOV 15 1938 W. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 14. 1938

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
 I last saw her..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 5.50 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Acute lobar pneumonia  
 108  
 Other contributory causes of importance:  
 Name of operation..... Date of.....  
 What test confirmed diagnosis autopsy 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 no  
 If so, specify..... (Signed) John O. Powell M. D.  
 Coroner of St. Louis County, Mo.

STATEMENT BY LICENSED EMBALMER

I, *A. J. Neely*, Licensed Embalmer No. 3225

hereby certify that the body recorded on the reverse side of this certificate was embalmed by *me*

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

*A. J. Neely*  
Licensed Embalmer No. 3225

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)