

27482

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **20233**

FILED JUN 1 1944

Registration District No. **318**Primary Registration District No. **1003**Registrar's No. **5099**

## 1. PLACE OF DEATH:

(a) County.....  
 (b) City or town..... **St. Louis, Missouri**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**St. Louis City Hospital**  
 (If not in hospital or institution, write street number or location) **0**  
 (d) Length of stay: In hospital or institution..... **5 days**  
 (Specify whether  
 In this community.....  
 years, months or days)

3. (a) PRINT FULL NAME **MARTIN SCHMITT**3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **4**

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**about 62** hr. min.9. Birthplace **unknown** (City, town, or county) (State or foreign country) **4**10. Usual occupation **Baker**

11. Industry or business

12. Name **unknown**13. Birthplace **unknown** (City, town, or county) (State or foreign country) **4**14. Maiden name **unknown** (City, town, or county) (State or foreign country) **4**15. Birthplace **Father Willms** (City, town, or county) (State or foreign country) **4**16. (a) Informant **Hogan & N. Market St.**17. (a) **Burial** (b) Date thereof **6-5-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Calvary Cemetery**18. (a) Signature of funeral director **Hy. Leidner U. Co.**(b) Address **2223 St. Louis Ave.**19. (a) **JUN 2 1944** (Date received local registry) **G. T. Bueck** (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **000**  
 (c) City or town..... **St. Louis**  
 (If outside city or town limits, write "RURAL") **17**  
 (d) Street No. **1413a N. Market St.**  
 (If rural, give location) **269**  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country..... **11**

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **2nd**  
year **1944** hour **3** minute **40 A.M.**21. I hereby certify that I attended the deceased from **April 29th**  
**1944**, to **June 2nd**, 19 **44**that I last saw him alive on **June 2nd**, 19 **44**  
and that death occurred on the date and hour stated above.Immediate cause of death  
**Fibrosarcoma of pharynx with metastases** **2 yrs**  
Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**Of autopsy **none**

## PHYSICIAN

Underline the cause to which death should be charged statistically.

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
 (b) Date of occurrence.....  
 (c) Where did injury occur?..... (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury

23. Signature **W. J. Verdo** (M. D. or other) **6/2/44**  
Address **1515 Lafayette** Date signed

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *John P. Bachholz*  
Licensed Embalmer No. *222 167*  
P. O. Address *2223 St. Louis*

**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.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... years, months or days)

3. (a) PRINT FULL NAME Martin Schmitz

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced unk  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 62 Months Days unk If less than one day, min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

{ 13. Birthplace..... (City, town, or county) (State or foreign country)

{ 14. Maiden name.....

{ 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) JUN 27 1944 (b) J. F. Prudek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 14 year 1944 hour unk minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

20233