S. No. 2
A—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED APR 3 1948

Registration District No. 1

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 10639

Registrar's No. 2796

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

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-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) 35 YRS.
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1844 S. 9th ST.
Memorial (If rural, give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Stephania Schmidt
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FEMALE
5. Color or race White
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased UNKNOWN (Month) (Day) (Year)
8. AGE: Years 63 Months — Days — If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation PACKER
11. Industry or business
MOTHER FATHER
12. Name UNKNOWN
13. Birthplace HUNGARY (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace HUNGARY (City, town, or county) (State or foreign country)
16. (a) Informant MRS. MAMIE LAMBERT
(b) Address 2424 MISSOURI
17. (a) ~~BURIAL~~ Removal (Burial, cremation, or removal) (b) Date thereof MAR. 23 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Wonderlie Lee SUNSET HILL CEM. ILLINOIS
18. (a) Signature of funeral director Thomas Kiti & Son
(b) Address 2906 GRAVOIS
19. (a) MAR 22 1948 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 21st year 1948 hour 9 minute 50 A.M.
21. I hereby certify that I attended the deceased from 3/20/48, 19..., to March 21st, 19 48 that I last saw her alive on March 21st, 19 48 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
hypertension	
cardiovascular disease	unknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) carcinoma of breast	
paranoid schizophrenia	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. J. Wright (M. D. or other)
Address 1515 Lafayette Date signed 3/22/48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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 Homer C Mill

Licensed Embalmer No. 4347

P. O. Address 2906 Gravois

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2796

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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Stephania Schmidt

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

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

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

8. AGE: Years 63 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

APR 9 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

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

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-10639