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

Do not use this space.

38706

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11123

City St Louis Mo (No. St Mary's Infirmary St. ..... Ward)

2. FULL NAME Felix Schoenemann

(a) Residence. No. 4242 S N Florissant Av 9 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 28 1898

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	31	9	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Carl Schoenemann

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Johanna Dickman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Lucille Schoenemann
(Address) 4242 N Florissant

15. FILED NOV 14 1929, 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 25 PM 11/13/ 1929.

17. I HEREBY CERTIFY, That I attended deceased from 10/30/29, 19..., to 11/13/29, 19..., that I last saw h.i.m. alive on 11/13/29, 19..., and that death occurred, on the date stated above, at 1 25 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brain tumor Benign
[illegible]
109 B
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Bronchio-pneumonia
..... (duration) ..... yrs. ..... mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? yes. DATE OF 11/10/29
WAS THERE AN AUTOPSY? yes.
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Warren G Marston, M. D.
11/14, 1929 (Address) 1532 Papin

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Friedens	Nov 16 1929

20. UNDERTAKER	ADDRESS
Math Hermann & Son	2161 Pair Av

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.

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