

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

Do not use this space.

7015

1. PLACE OF DEATH

County..... Registration District No. **7911**
Township..... Primary Registration District No. **003**
City..... **St. Louis** (No. St. Ward)

File No.
Registered No. **1881**

2. FULL NAME

Barbara Schwarz

(a) Residence. No. **5468 Partridge St.** **7** 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 25 1852**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 **1** **26**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

10. NAME OF FATHER **Jacob Weiss**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Barbara Rothgeber**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

14. INFORMANT **Barbara Metzger**
(Address) **5468 Partridge Ave**

15. FILED **May 19 1930**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb - 21 - 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Feb 14th** 1930, to **Feb 21** 1930 that I last saw him alive on **Feb 21** 1930, and that death occurred, on the date stated above, at **3:15** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
(duration) yrs. mos. **7** ds.

CONTRIBUTORY (SECONDARY) **Senility**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Place of Death**
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

19. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **auscultation**
(Signed) **A. Gettinger** M. D.

, 19 (Address) **2745 N Grand Ave**

*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 **Peter & Paul** DATE OF BURIAL **21 Feb 1930**

20. UNDERTAKER **Edw. Koch** ADDRESS **3516 N 14th St**

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.

