

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

Do not use this space.

7470

1. PLACE OF DEATH

County..... Registration District No. 1781
Township..... Primary Registration District No. 1003
City St. Louis (No. City Hospital)

File No.
Registered No. 1799
St. Ward)

2. FULL NAME Henry Schroeder (SCHROEDER)
(a) Residence. No. 2501 N. 9th St. 26 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 12 1870</u>		
7. AGE	YEARS <u>60</u>	MONTHS <u>7</u>
	DAYS <u>28</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Sawyer 9th</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
10. NAME OF FATHER <u>Henry Schroeder Sr</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>		
12. MAIDEN NAME OF MOTHER <u>Josephine Schli</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1931
17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1931 to Feb 9 1931 that I last saw him alive on Feb 9 1931 and that death occurred, on the date stated above, at 6:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Myocarditis
930
10-1-18 (duration) yrs. mos. ds.
CONTRIBUTORY Acute Infectious Arthritis (SECONDARY) (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED? 930
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
19 (10) (Signature) Jerome Simon (Address) City Hospital

*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.

14. INFORMANT (Address) City Hospital
15. FILED 1931 REGISTRAR Max C. Hunter
19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Johns North DATE OF BURIAL Feb 12 1931
20. UNDERTAKER Math Hermann & Son 2161 Fairview ADDRESS

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

Leander