

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.

REC'D NOV 16 1938

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

33997
 Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**

(b) Township..... Primary Registration District No. **1008**

(c) City **St. Louis, Missouri** (d) Street No. **City Sanitarium** St. **8983**
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred **64** yrs. **4** mos. **9** ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Theresa Schmidt**

(a) Residence, No. **2626 Clara Ave.** St. **6**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 3, 1875**

7. AGE YEARS **63** MONTHS **4** DAYS **9** If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housework**

9. Industry or business in which work was done, as saw mill, bank, etc. **Housework**

10. Date deceased last worked at this occupation (month and year) **1919** 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) **St. Louis, Missouri.**

FATHER

13. NAME **Albert Nathias**

14. BIRTHPLACE (CITY OR TOWN) **Unknown** (STATE OR COUNTRY) **Germany**

MOTHER

15. MAIDEN NAME **Mary Siesle**

16. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Missouri**

17. INFORMANT (ADDRESS) **Hubert P. Smith 5400 Arsenal Dr**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Oct. 15 38**

19. FUNERAL DIRECTOR (NAME) **John F. Stuart** (ADDRESS) **1235 Union Blvd**

20. FILED **OCT 14 1938** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10-12-38** 19

22. I HEREBY CERTIFY, That I attended deceased from **7-1-38** 19 to **10-12-38** 19. I last saw him alive on **10-12-38** 19. Death is said to have occurred on the date stated above, at **11:15 A.M**

The principal cause of death and related causes of importance were as follows:
Broncho-pneumonia 10-12-38 Date of onset

Other contributory causes of importance:
Epilepsy 10-12-38 with psychosis

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) **Hubert P. Smith** M. D.
 (Address) **5400 Arsenal Dr**

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,

BERNARD A. J. STUART

or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Bernard A. J. Stuart

Licensed Embalmer No.

3500

P. O. Address.....

5318 Kilmear

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, above space should be left blank.