

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 917
Registrar's No. 917

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis FILED FEB 1 1940
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3335 S. 2nd St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 24
(If outside city or town limits, write "RURAL")
(d) Street No. 3335 S. 2nd St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Gustav Schmitt 5312

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased November 20, 1859
(Month) (Day) (Year)

8. AGE: Years 80 Months 2 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace St. Genevieve Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business City Paving

12. Name Bernard Schmitt

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Theresa Doll

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Schmitt

(b) Address 3335 S. 2nd St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/40
(Month) (Day) (Year)

(c) Place: burial or cremation O. S. S. Peter & Paul
Mackey-Welder

18. (a) Signature of funeral director J. J. Pender
(b) Address 2331 S. Broadway

19. (a) JAN 30 1940 (Date received local health officer) (b) J. J. Pender (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27
year 1940 hour 9 minute 30 pm.

21. I hereby certify that I attended the deceased from 4-15-1935, to 1-27-1940,
that I last saw him alive on 1-24-1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis?
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature W. Jones (M. D. or other) MD
Address 3616 S. Broadway Date signed 1-29

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

USE CARBONIC BLACK INK—MAKE 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.

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..... *Frank J. Myland Sr.*
Licensed Embalmer No. *2675*
P. O. Address..... *St Louis Mo*

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.