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

Do not use this space.

12613

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. 5617 Dewey Ave St. ..... Ward)

File No. .....

Registered No. 3142

2. FULL NAME Rudolph Schwietzer

(a) Residence. No. 5617 - Dewey Ave St., 15 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: Male

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: Grace Schwietzer

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 27 - 1884

7. AGE: Years 45 | Months 1 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Saloon Keeper

(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): St Louis Mo

PARENTS

10. NAME OF FATHER: Fred. Schwietzer

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

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St Louis Mo

14. INFORMANT (Address): Grace Schwietzer 5617 - Dewey Ave

15. FILED ..... 19 ..... Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 11 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 6 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxiation Due to Fuel Gas Poisoning

16 - C (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Suicide

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kemper, M.D.

3/13, 1929 (Address) Dep Coron

*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: New Salem Cemetery

DATE OF BURIAL: Mar 12 1929

20. UNDERTAKER: Wacker-Helderle

ADDRESS: 2331-S Bdwy

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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