

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

Do not use this space.

~~20820~~
20820
Registered No. **5618**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis Mo.** (No. **1612 St. 19th St**)

2. FULL NAME

Catherine M. Schwartz
(a) Residence. No. **1612 St. 19th St** St. **8 26** 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 <i>Female</i>		4. COLOR OR RACE <i>White</i>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Emile Schwartz</i>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Nov. 28 - 1877</i>					
7. AGE	YEARS <i>52</i>	MONTHS <i>6</i>	DAYS <i>10</i>	IF LESS than 1 day, _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer.					
9. BIRTHPLACE (CITY OR TOWN) <i>St. Louis Mo.</i> (STATE OR COUNTRY)					
PARENTS	10. NAME OF FATHER <i>John Sebald</i>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>				
	12. MAIDEN NAME OF MOTHER <i>Don't know</i>				
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>					
14. INFORMANT <i>Emile Schwartz</i> (Address) <i>1612 St. 19th St.</i>					
15. COPIED TO FILE _____ FILED _____ 19 _____ REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 8 1930*

17. I HEREBY CERTIFY, That I attended deceased from *May 24*, 1930, to *June 8*, 1930, and that I last saw her alive on *June 8*, 1930, and that death occurred, on the date stated above, at *8:30 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
gangrene of the lung
114B (duration) _____ yrs. _____ mos. *15* ds.

CONTRIBUTORY (SECONDARY) *104* (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *NO*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *George Mueller*, M. D.
June 9, 1930 (Address) *1502 St. Louis*

*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 <i>Calvary</i>	DATE OF BURIAL <i>June 12 1930</i>
20. UNDERTAKER <i>Wm. Leidner and Co.</i>	ADDRESS <i>1417 N. Market St.</i>

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.

