

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.

MAR 24 1934

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

Do not use this space.

CERTIFICATE OF DEATH  
RESPIRATION HOSPITAL

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No.....  
Primary Registration District No. *1003*

File No. *6438*  
Registered No. *1273*  
St. .... Ward)

**2. FULL NAME**

*Edward Schwartz*

(a) Residence, No. *2720 Tennessee* St. *11th* Ward.  
(Usual place of abode)  
Length of residence in city or town where death occurred, *4 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Nov. 22, 1930</i>		
7. AGE YEARS <i>3</i>	MONTHS <i>2</i>	DAYS <i>25</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>nil</i>		11. Total time (years) spent in this occupation.....
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year).....		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 3, 1934*  
22. I HEREBY CERTIFY, That I attended deceased from *Jan 29, 1934* to *Feb 3, 1934*  
I last saw him alive on *Feb 3, 1934* Death is said to have occurred on the date stated above, at *3:05 a.m.*

The principal cause of death and related causes of importance were as follows:  
*Scarlet Fever* Date of onset *1-8*

Other contributory causes of importance:  
*Cervical adenitis*  
Name of operation *Dissection* Date of *Feb 2-2*  
What test confirmed diagnosis? *Culture* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? *No* Date of injury....., 19.....  
Where did injury occur? *No* (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? *No*  
If so, specify *John Eschenbrenner M.D.*  
(Signed) *John Eschenbrenner M.D.*  
(Address) *RESPIRATION HOSPITAL*

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Overland Mo.</i>
	13. NAME <i>Rudolph Schwartz</i>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>
	15. MAIDEN NAME <i>Katherine Goldman</i>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Missouri</i>
17. INFORMANT <i>Grace Barry</i> (ADDRESS) <i>6300 Orange St.</i>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Cahany</i> DATE <i>Feb 6, 1934</i>	
19. UNDERTAKER <i>Arthur J. Donnelly, 2160</i> (ADDRESS) <i>3840 Lindbergh Ave.</i>	
20. FILED <i>FEB - 5 1934</i> <i>J. J. Brudeck</i> Registrar.	

