

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.

OCT 14 1937

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

32323  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
(b) Township..... Primary Registration District No. **1003**  
(c) City **St. Louis,** (d) Street No. **De Paul Hospital** Registered No. **8377**  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME **Thomas Carl Schweizer**

(a) Residence, No. **3444 Tennessee Ave.** St. **16**  
(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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug. 9, 1937.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
**-- -- 27**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **None**

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

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

13. NAME **Geo. Schweizer**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

15. MAIDEN NAME **Albertine Zoellner**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Perry Co. Mo.**

17. INFORMANT (ADDRESS) **George J. Schweizer**  
**3444 TENNESSEE**

18. BURIAL, CREMATION, OR REMOVAL

**SS. Beter & Paul Cem. DATE Sept. 7, 1937.**

19. FUNERAL DIRECTOR (ADDRESS) **J. N. Gubken & Co.**  
**2630 Grayson Ave.**

20. FILE **SEP 1** 19 **J. H. Predeck**  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 5, 1937**

22. I HEREBY CERTIFY, That I attended deceased from **Aug. 21, 1937 to Sept. 5, 1937**

I last saw him alive on **Sept. 5, 1937** Death is said to have occurred on the date stated above, at **3:30 P.M.**

The principal cause of death and related causes of importance were as follows:

**Intracranial hemorrhage**  
**Pneumonia, Rt. lobar**  
Date of onset **Birth 9-4-37**

Other contributory causes of importance:

**Prematurity, malnutrition**  
**Atresia**

Name of operation **None** Date of

What test confirmed diagnosis? **Autopsy** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

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) **Ben M. Bull** M. D.

(Address) **4932 Maryland Ave**

Dr Bull  
4932 Maryland Ave

STATEMENT BY LICENSED EMBALMER

I, John H. Gebken, Licensed Embalmer No. 500

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed John H. Gebken

Licensed Embalmer No. 500

**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.)**