

REC'D FEB 10 1939

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

102  
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. City Hospital No. 1  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(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.

## 2. PRINT FULL NAME

Werner Schwerzler  
(a) Residence, No. 4669 Loughborough  
(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) July 24, 1937		
7. AGE YEARS 1	MONTHS 5	DAYS 10
If LESS than 1 day, ..... hrs. or ..... min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. nil	
FATHER	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri	
	13. NAME Werner Schwerzler	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri	
15. MAIDEN NAME Katherine Stillinovic		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri		
17. INFORMANT Hosp. Info M. Kent		
18. BURIAL, CREMATION, OR REMOVAL Schelton + Paul DATE 1-5-39		
19. FUNERAL DIRECTOR (NAME) Dr. C. Maydell (ADDRESS) 1936 Allen St.		
20. FILED JAN 4 1939 J. D. Brubaker Local Registrar		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/3/39

22. I HEREBY CERTIFY, That I attended deceased from 12/30/38, 19....., to 1/3/39, 19.....  
I last saw him alive on 1/3/39, 19..... Death is said to have occurred on the date stated above, 5.25 a.m.  
The principal cause of death and related causes of importance were as follows:  
Tracheitis, acute  
Bronchitis, acute  
(had swallowed peach seed days or two previous to hospital entrance which he had phared in stool)  
Other contributory causes of importance:  
Possibly secondary to TB. in lungs.  
Name of operation Tracheotomy Date of 2/3/39  
What test confirmed diagnosis? Smear Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
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) A. J. Kowalle, M. D.  
(Address) City Hospital No. 1

**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 Benny C. Thurman  
Licensed Embalmer No. 2373  
P. O. Address 181 E. Allen Ave

**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.**