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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

REC'D OCT 14 1939 791

Registration District No. 107

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 1

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4143 Schiller Place.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Infant Nischwitz 237

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1939 hour 11 minute 56 A M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 27, 1939
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

STILL BORN

Immediate cause of death St. II Birth -

Due to _____

Due to _____ (2)

Other conditions _____
(Include pregnancy within 8 months of death)

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name Harold Nischwitz

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Luella Budde

15. Birthplace New Baden Illinois
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Harold Nischwitz

(b) Address 4143 Schiller Place

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) Burial (b) Date thereof Sept. 29/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S.S. Peter and Paul Cm.

While at work _____ (Specify type of place) _____

(e) Means of injury _____

23. Signature John A. Barrow (M. D. or other) MD

Address Jan S. Traud Date signed 9/28/39

18. (a) Signature of funeral director Weick Bros. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) SEP 27 1939 (Date entered local register)

J. F. Budde (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FORM 5-17-39
Rev. 5-17-39
U.S. GOVERNMENT PRINTING OFFICE

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.

NOT EMBALMED

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.