

Registration District No. **1003**

Primary Registration District No. _____

Registrar's No. **8965**

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **St Louis**
(c) Name of hospital or institution: **City Hospital**
(d) Length of stay: In hospital or institution **Worked At Hospital**
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St Louis Mo**
Street No. **5468 Partridge Ave**
(e) If foreign born, how long in U. S. A. **1904** years.

3. (a) PRINT FULL NAME **Henry Schwartz also known as Michael Schwartz**

3. (b) If veteran, name war _____ No. _____

4. Sex **Male** 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 **December 26 Th 1885**
(Month) (Day) (Year)

8. AGE: Years **53** Months **9** Days **26** If less than one day _____ hr. _____ min.

9. Birthplace **Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business **City Hospital**

12. Name **Joseph Schwartz**

18. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Barbara Weiss**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address **5468 Partridge Ave**

17. (a) **Burial** (b) Date thereof **Oct 23 D 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Peter & Paul Cen**

18. (a) Signature of funeral director **Edward Koch**

(b) Address **3516 N. 14 TH Str**

19. (a) **OCT 21 1939** (b) _____
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **20**
year **29** hour **5** minute **05 PM**

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.

Immediate cause of death **Coronary Occlusion, Arteriosclerosis.** Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (Means of injury)

23. Signature _____ (M. D. or other)

Address _____ Date signed **10/21/39**

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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.....

Harry J. Schumacher

Licensed Embalmer No. *2679*

P. O. Address. *732 Kenney*

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.