DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39700

Registration District No. 784 — Primary Registration District No. 101 — Registrar's No. 2105

FILED DEC 7 1940

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7518 Cromwell
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County ____
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. 7518 Cromwell Dr.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Edith Schwartz
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Moses L. Schwartz
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept. 22 1871 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
69	1	15	hr. ____ min.

9. Birthplace ____ (City, town, or county) Roumania (State or foreign country)
10. Usual occupation at home
11. Industry or business
MOTHER FATHER
12. Name (unk)
13. Birthplace (unk) (City, town, or county) (State or foreign country)
14. Maiden name (unk)
15. Birthplace (unk) (City, town, or county) (State or foreign country)
16. (a) Informant Mr. Al Feldman
(b) Address Nashville Tennessee
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11/8/40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Heb.
18. (a) Signature of funeral director H.B.Berger
(b) Address 4715 McPherson
19. (a) NOV 8 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7th day Nov. year 1940 hour 12 minute 20A M.
21. I hereby certify that I attended the deceased from June 1938, 19__, to Nov 7, 1940 that I last saw her alive on Nov 6, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation
Due to arteriosclerotic heart disease
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature A Feldman (M. D. or other) [signature]
Address 634 IV Grand Date signed 11/7/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....1597

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.