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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5539**
Registrar's No. **1787**

MAR 25 1941 791 1

Registration District No. _____ Primary Registration District No. **1003**

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

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1. PLACE OF DEATH:

(a) County Missouri
(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. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether
In this community 1 1/2 yrs. years, months or days)

3. (a) PRINT FULL NAME Arthur Schweppe

3. (b) If veteran, name war No 3. (c) Social Security No. 493-01-9675

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LOUISE SCHWEPPE 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased JANUARY 3 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 1 19 hr. min.

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

10. Usual occupation MILK DRIVER

11. Industry or business ST. LOUIS DAIRY CO.

MOTHER, FATHER { 12. Name AUGUST SCHWEPPE
13. Birthplace ST. LOUIS Mo.
(City, town, or county) (State or foreign country)
14. Maiden name LENA KNICK MEYER
15. Birthplace ST. LOUIS Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Louise Schweppe
(b) Address 5930 FLOY AVE.

17. (a) BURIAL (b) Date thereof FEB. 26 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ZION CEMETERY

18. (a) Signature of funeral director W. M. SCHUMACHER

(b) Address 4834 NATURAL BRIDGE

19. (a) FEB 25 1941 (b) J. T. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")
(d) Street No. 5930 FLOY AVE. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 22nd,
year 1941 hour 3 minute 45 P. M.

21. I hereby certify that I attended the deceased from 2/17/41
to 2/22/41, 19____, to _____, 19____;

that I last saw him alive on Feb. 22, 1941, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Bacterial Endocarditis Duration 2 weeks

Due to Pneumonia - Lobar

Due to Pneumonia meningitis

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

Major findings: Of operations _____

Of autopsy as above

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? _____

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

23. Signature Samuel Wallace (M. D. or other) _____
Address 1515 Lafayette Date signed 2/24/41

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.....

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, fact should be so stated above.