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-17-39  
X32873

FILED JAN 25 1943

State File No. ....

Registration District No. .... 2

Primary Registration District No. .... 1553

Registrar's No. .... 67

1. PLACE OF DEATH:

(a) County Buchanan

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

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

(d) Length of stay: In hospital or institution... 2 days  
(Specify whether years, months or days)

In this community... 9 years.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

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

(d) Street No. 548 W. Chestnut St.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Elsie Pauline Schweizer

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife William G. Schweizer 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased April 8 1901  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>9</u>	<u>9</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name August Breckel

13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Pauline Miller

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

16. (a) Informant William G. Schweizer

(b) Address 548 W. Chestnut St., St. Joseph

17. (a) Burial (b) Date thereof Jan. 19, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Herbert W. Sedwick  
(b) Address 1802 Union Str., St. Joseph, Mo

19. (a) 1-19-43 (b) Rae Hagan  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17th  
year 1943 hour 1 minute 45 A.

21. I hereby certify that I attended the deceased from Jan 11, 1943 to Jan 17, 1943  
that I last saw her alive on Jan 16, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolicism on Pulmonary Duration 1-17-43

Due to Acute Myocardial Insufficiency short

Due to Chronic Pyosalpinx of the uterus

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

Major findings:  
Of operations.....

Of autopsy.....

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 Mustard St. Lawrence (M. D. or other) M.D.

Address 1440 North Bell St. St. Joseph, Mo. Date signed 1-19-43

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

MOTHER FATHER

1233

**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.....

*Albert R. Harrington*

Licensed Embalmer No..... 3258

P. O. Address..... St. Joseph, Mo.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1662  
Registrar's No. 67

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME Elsie Pauline Schuey  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 8  
(Month) (Day) (Year)

8. AGE: Years 14 Months \_\_\_\_\_ Days \_\_\_\_\_ if less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 17 Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism

Due to acute myocarditis  
Insufficiency

Due to 139a

Other conditions Chronic Pyosalpingitis  
(Include pregnancy within 3 months of death)

Major findings: Of operations non-specific  
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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Gustav Law (M. D. or other) \_\_\_\_\_  
Address St Joseph, Mo Date signed 1-19-43

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

SUPPLEMENTARY

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is arranged in approximately 15 horizontal lines across the page. No specific words or phrases are discernible.]