

LED NOV 1 1943
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Firmin Desloge
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **one day**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Rosa Schwerzler**

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

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

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

7. Birth date of deceased **Unknown about 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 70 Unknown hr. min.

9. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **August Schnieder**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Pauline Brozka**

(b) Address **4654 Tyrolean Ave**

17. (a) **Burial** (b) Date thereof **10/26/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New S.S. Peter & Paul**

18. (a) Signature of funeral director **Wm. B. Moyall**

(b) Address **OCT 25 1943 1926 Allen Ave**

19. (a) **J. J. Budeck** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No. **4654 Tyrolean Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **23**
year **1943** hour **8** minute **12 A.** M.

21. I hereby certify that I attended the deceased from **Oct 22 43**
_____ 19____ to **Oct - 22 1943**
that I last saw **her** alive on **Oct - 22 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death
Rupture of Gall bladder
As Complication of (a)

Due to **1/21 Peritonitis**

Due to **1/21 Peritonitis**

Other conditions (Include pregnancy within 3 months of death)
Major findings: **Rupture of gall bladder**
Of operation: **gall stones - emphysema**
Of autopsy: **no**

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)
(a) Means of injury _____
23. Signature **Joseph L. Smith** (M. D. or other) **10/24/43**
Address **4065 S. Grand Ave.** Date signed **10/24/43**

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allenway

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.