

No. 2
-2-43
-17-39
X35957

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40528

FILED DEC 22 1943

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10824**

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:
Deaconess Hospital
(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. 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. 1043 S. Taylor Avenue,
(If rural, give location)

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

3. (a) PRINT FULL NAME Robert Maynard Schwab

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

3. (c) Social Security No. 191-10-8696

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

6. (b) Name of husband or wife Mary Elizabeth Cusack 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Oct. 21, 1912
(Month) (Day) (Year)

8. AGE: Years 31 Months 1 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Clerk, Monsanto Chemical Co.

11. Industry or business As above

MOTHER FATHER

12. Name Robert M. Schwab

13. Birthplace Buffalo, N. Y.
(City, town, or county) (State or foreign country)

14. Maiden name Carrie Abram

15. Birthplace Franklin Co., Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Carrie Schwab,

(b) Address 1043 S. Taylor Ave.

17. (a) Burial (b) Date thereof 12/9/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) DEC 8 1943 (b) J. F. Bredich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6 year 1943 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from 11/29/43 to 12/6/43, 19____; that I last saw him alive on 12/6/43, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Exp. R. thalamic gaitic and acute post-operative thyroid crisis

Due to P.O. Pneumonia

Due to acute myocardial infarction

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

Major findings: hypertensive gaitic

Of operations _____

Of autopsy Yes Bronchopneumonia

Duration 6 wks.

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 _____

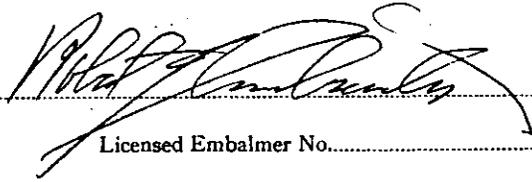
23. Signature J. F. Bredich (M. D. or other) _____

Address: Mo. Theater Bldg. Date signed 12/7/43

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

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.