

Registration District No. **318** Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **St Louis Mo.**  
(b) City or town **St Louis Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**City Hospital No 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 Day**  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT FULL NAME **JOSEPHINE SCHWARTZ SAAK**

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **March 22 1886**  
(Month) (Day) (Year)

8. AGE: Years **59** Months **2** Days **4** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **At Home**

11. Industry or business **Housewife**

MOTHER { 12. Name **George Schwartz**

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

14. Maiden name **Anna Gerdes**

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

16. (a) Informant **Anna Luft**

(b) Address **1621 S 9th St**

17. (a) **Burial** (b) Date thereof **May 31/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St Peter's Paul**

18. (a) Signature of funeral director **Th. Rodolakis & Son**

(b) Address **2906 Gravois Ave.**

19. (a) **MAY 29 1945** (Date received local registrar) **J. F. Busch** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**  
(c) City or town **St Louis** **023**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **910 Julia St**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **26**  
year **1945** hour **12 45** minute **P.M.**

21. I hereby certify that I attended the deceased from **5/25/45**  
\_\_\_\_\_ 19 \_\_\_\_\_ to **5/26/45** 19 \_\_\_\_\_  
that I last saw **her** alive on **5/26/45** 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death **cholecystitis** Duration **4d.**  
**Hepatitis & Cholangitis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations **0**

Of autopsy **none**

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 **M. Hana** (M. D. or other) \_\_\_\_\_

Address **1515 Lafayette** **5/28/45**

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

17  
9

**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

*David Tau Fossan*

Licensed Embalmer No.....

*4242*

P. O. Address

*2906 Harrison*

**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.**