

FILED AUG 11 1945

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 19372

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County 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 Missouri (b) County St. Louis  
(c) City or town University City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1308 Waldron  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ellen Schwienher

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

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

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

7. Birth date of deceased June 4, 1860  
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 29 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 Never employed

12. Name Bernard Quigley

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

14. Maiden name Ellen McMannes

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

16. (a) Informant James B. Schwienher

(b) Address 1308 Waldron Ave.

17. (a) Burial (b) Date thereof 8/6/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

(b) Address Clayton Rd. at Concordia Lane

19. (a) 8-6-45 (b) E. S. Mc Gowan MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month August day 3  
year 1945 hour 7 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 7/8/45  
19\_\_\_\_ to 8/3/45 19\_\_\_\_;  
that I last saw her alive on 8/3/45 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 3 d

~~Fracture of left femur~~ 24 days  
~~Generalized arteriosclerosis~~

Due to 1945-1

Other conditions (Include pregnancy within 3 months of death) 1/8

Major findings: Of operations \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

Of autopsy \_\_\_\_\_ 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. W. Huttell (M.D.)  
Address St. Louis County Hosp Date signed 8/4/45

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. 1997

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.**