

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

22185

FILED JUN 26 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5400**

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: **5622 Finkman**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community **70 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

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

(d) Street No. **5622 Finkman**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) **0**

If yes, name country _____

3. (a) PRINT FULL NAME **Michael Schwan**

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 **Widower**

6. (b) Name of husband or wife **Josephine**

6. (c) Age of husband or wife if alive **--** years

7. Birth date of deceased **April 26 1856**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **17** year **1946** hour **1** minute **06A.** M.

21. I hereby certify that I attended the deceased from **July 10 1946** to **July 17 1946**

that I last saw him alive on **May 21 1946** and that death occurred on the date and hour stated above.

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| 90 | 1 | 21 | hr. min. |

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

10. Usual occupation **Barber**

Immediate cause of death **chronic myocarditis, bronchial asthma, senility**

Due to **generalized arteriosclerosis**

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

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

16. (a) Informant **Meta Nelson**

(b) Address **5622 Finkman**

17. (a) **Burial** (b) Date thereof **6/19/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **O. SS Peter & Paul**

18. (a) Signature of funeral director **Wacker - Hebl**
3634 Gravois Ave.

(b) Address _____

19. (a) **JUN 18 1946** (b) **J. F. Braddock**
(Date received local registrar) (Registrar's signature)

23. Signature **A. J. Murlin M.D.** (M. D. or other) _____

Address **3507 Potomac** Date signed **6-17-46**

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

MOTHER FATHER

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..... *Robert Cowie*

Licensed Embalmer No. *2128*

P. O. Address..... *Alhambra*

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.