No. 300
10.48

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3250

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1033

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7002 Bancroft Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Cole
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jefferson City
d. STREET ADDRESS (If rural, give location) 903 Monroe

3. NAME OF DECEASED (Type or Print)
a. (First) Anna
b. (Middle) Frances
c. (Last) Schwaller

4. DATE OF DEATH (Month) 2 (Day) 1 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH July 25, 1867
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Kroki, Poland
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Niewodoske
13b. MOTHER'S MAIDEN NAME Amelia Kellener
14. NAME OF HUSBAND OR WIFE Frank X. Schwaller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Louis P. Schwaller, 3632 Watson Rd. ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 3317
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-3, 1947, *to* Feb 1, 1949, *that I last saw the deceased alive on* 1-31, 1949, *and that death occurred at* 1:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph E. Carney MD (Degree or title)
23b. ADDRESS 906 Olive St
23c. DATE SIGNED 2-2-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 2-3-49
24c. NAME OF CEMETERY OR CREMATORY St. Peters
24d. LOCATION (City, town, or county) Jefferson City, Mo. (State)

DATE REC'D BY LOCAL REG. FEB 2 1949
REGISTRAR'S SIGNATURE J B Lacater
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

FEB 8 1950

OCT 30 1950

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

..... Student Embalmer No. .....,

working under my personal supervision.

Signed Elton H. Remelius

Signed .....
Student Embalmer

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo

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.