

FILED MAR 31 1950

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

11075

State File No. 2816

318

1002

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		7/4	
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL				d. STREET ADDRESS (If rural, give location) 246 3326 WISCONSIN			
3. NAME OF DECEASED (Type or Print) a. (First) KATHERINE		b. (Middle)		c. (Last) SCHWARZ		4. DATE OF DEATH (Month) (Day) (Year) MAR. 23 1950	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 17 1885	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 6	IF UNDER 1 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 AT Home		11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN DONNAWELL		13b. MOTHER'S MAIDEN NAME MARIE GLASSEN		14. NAME OF HUSBAND OR WIFE JOHN SCHWARZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOHN SCHWARZ 3326 WISCONSIN			
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diabetic acidosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetic gangrene - 16 foot</u>					INTERVAL BETWEEN ONSET AND DEATH 1 wk   3 wks	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 21st St MO			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> 19 <u>43</u> , to <u>March 23</u> 19 <u>50</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>50</u> , and that death occurred at <u>5:30 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>P. A. Neidhauser M.D.</u>			23b. ADDRESS <u>3701 Grand St. Sq.</u>			23c. DATE SIGNED <u>3-24-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAR. 27 1950	24c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO			
DATE REC'D BY LOCAL REG. MAR 24 1950		REGISTRAR'S SIGNATURE <u>J B Lester</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutia 7906 Gravois</u>			

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Travis

**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.