

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016 Registrar's No. 165

264

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

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY OR TOWN <u>Jefferson City</u>		c. CITY OR TOWN <u>Jefferson City</u>	
c. LENGTH OF STAY (in this place) <u>85 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>810 Washington</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>810-Washington</u>			

3. NAME OF DECEASED (Type or Print) <u>Vetena Barbara Schwartz</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 9-1952</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Nov. 12, 1866</u>		9. AGE (in years last birthday) <u>85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dressmaking</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Jefferson City, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Adam Schwartz</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Barbara Kern</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Lydia Schwartz - J.C. Mo.</u>	ADDRESS <u>J.C. Mo.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
	ANTECEDENT CAUSES Morbidity 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.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 6/27, 1952, to 7/9/52, 1952, that I last saw the deceased alive on 7/7, 1952, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Edward G. G. M.D.</u>	23b. ADDRESS <u>Jefferson City, Mo</u>	23c. DATE SIGNED <u>7/9/52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 11, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Evangelical</u>	24d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo</u>
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DATE REC'D BY LOCAL REG. <u>July 9-1952</u>	REGISTRAR'S SIGNATURE <u>R.P. Davis M.D. - MR.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel ...</u>	ADDRESS _____
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embalmer

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 *J. H. Mulvan*

Licensed Embalmer No. *3641*

P. O. Address *J. H. Mulvan*

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.