

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22624**
Registrar's No. **5514**

BIRTH NO. **39265** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 2709	
c. LENGTH OF STAY (In this place) 40 MIN.		d. STREET ADDRESS (If rural, give location) 20 7313 WARREN ST.	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) INFANT b. (Middle) SCHWEGLER c. (Last)		14. DATE OF DEATH (Month) (Day) (Year) JUNE 14, 1952	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JUNE 14, 1952
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOSEPH SCHWEGLER		13b. MOTHER'S MAIDEN NAME GRACE L WEST	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME GRACE WEST	
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, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Failure of Respiratory Center ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature delivery - 6 1/2 mo Gestation 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 40		19. DATE OF OPERATION	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 7735		22. I hereby certify that I attended the deceased from June 14, 1952 , to June 14, 1952 , that I last saw the deceased alive on June 14, 1952 , and that death occurred at 11:30 a.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) C. A. Prideman M.D.		23b. ADDRESS 4126 S. Shrew Ave	
23c. DATE SIGNED 6/15/52		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 6-16-52		24c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY	
24d. LOCATION (City, town, or county) (State) KIRKWOOD MO.		25. FUNERAL DIRECTOR'S SIGNATURE J. Earl Smith, M.D.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 16 1952		ADDRESS MITTELBERG FUNERAL HOME, INC. 73 W. LACKWOOD WEB. GRO. MO.	

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.....

.....
working under my personal supervision.

Student Embalmer No.

Student
Student Embalmer

NOT EMBALMED
Signed.....

Licensed Embalmer No.....

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.