

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004620

STATE FILE NUMBER

FILED MAR 16 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 262

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-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph 6117 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1706 Howard St.,		Length of stay in 1b Life	d. STREET ADDRESS (If outside, give location) 1702 Howard St., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Mary Louise Schwartz			4. DATE OF DEATH Month Day Year March 11, 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1895	9. AGE (In years last birthday) 64	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Cosby, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles Schwartz	13b. MOTHER'S MAIDEN NAME Emma Lederer	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Harold Poage, St. Joseph, Missouri Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>+ 3 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>thrombophlebitis, st leg</u> DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>pt usual cold previous</u> <u>46 3X</u>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>1-26-59</u> to <u>3-11-59</u> and last saw her ^{him} alive on <u>3-10-59</u> Death occurred at <u>10:30</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William A Ames, M.D.</u>	22b. ADDRESS <u>902 Edmund</u>	22c. DATE SIGNED <u>3-12-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Mar. 14, 1959	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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24. FUNERAL DIRECTOR <u>Wm. A. Ames</u>	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Mar. 13 1959	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Woodell</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Dr. William Ames
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

VS
MAY 12 1960
SA

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
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 4679

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.