

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027183

FILED VS AUG 4 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 6844** STATE FILE NUMBER

INDEXED

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|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                         |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |                                                                                                                                                                          |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                  |  | Length of stay in 1b<br><b>Life</b>                                                                                           | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>De Paul Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                          | d. STREET ADDRESS (If outside, give location)<br><b>4257 Red Bud Avenue, 15</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|----------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>JENNIE</b> Middle Last <b>SCHWARZE</b> |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>20th</b> , Year <b>1959</b> |  |  |  |
|----------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------|--|--|--|

|                         |                                  |                                                                                                                                                             |                                     |                                     |                                |                              |
|-------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-27-87</b> | 9. AGE (last birthday)<br><b>71</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|--------------------------------|------------------------------|

|                                                                                                                 |                                                      |                                                                          |                                           |
|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------|

|                                            |                                                     |                                                           |
|--------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|
| 13a. FATHER'S NAME<br><b>Henry Schutte</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Susan Mc Mullen</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Late Harry Schwarze</b> |
|--------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|

|                                                                                                                       |                                        |                                                                             |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT<br><b>Mrs. Annabelle Langer, 8223 Davenport Dr</b><br>Address |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------|

|                                                                                                          |                                                   |                                  |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |                                                   | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b>                                                             |                                                   | <b>3 years</b>                   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b) <b>Arterio Sclerotic Heart Disease</b> | <b>5 years</b>                   |
|                                                                                                          | DUE TO (c) <b>260x</b>                            |                                  |

|                                                                                                                                   |                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                |                                                                                                           |                                                                                              |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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.) |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|

|                                                           |                                                                                                        |                                                                                          |                                              |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------|
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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<br>COUNTY STATE |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------|

|                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 21. I attended the deceased from <b>Nov. 1949</b> to <b>July 20</b> and last saw her <b>him</b> alive on <b>July 20, 1959</b><br>Death occurred at <b>11:25P</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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|                                                            |                                            |                                    |
|------------------------------------------------------------|--------------------------------------------|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>H. J. Houch MD.</b> | 22b. ADDRESS<br><b>8907 Riverview Blvd</b> | 22c. DATE SIGNED<br><b>7-21-59</b> |
|------------------------------------------------------------|--------------------------------------------|------------------------------------|

|                                                             |                             |                                                                     |                                                                                    |
|-------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>7-24-59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Missouri</b> |
|-------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------|

|                                                                                                                      |                                                   |                                                      |
|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------|
| 24. FUNERAL DIRECTOR<br><b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd.,<br/>FUNERAL HOME, St. Louis, 5, Missouri.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 23 '59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b> |
|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m. g. 13.*

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 Ralph L. Timmer

Licensed Embalmer No. 4215

P. O. Address St. Louis

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.