URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH
FILED VS NOV 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9722 STATE FILE NUMBER 59-038069

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4207 E. Labadie Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: SARAH Middle: NMN Last: SCHWARTZ
4. DATE OF DEATH: Month: OCTOBER Day: 20 Year: 1959
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 7/7/1903
9. AGE (last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nil
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (City and state or country): St/Louis,Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Henry Schwartz
13b. MOTHER'S MAIDEN NAME: Amanda
14. NAME OF HUSBAND OR WIFE: ------
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: 489-28-1733
17. INFORMANT: Pearl Schwartz
Address: 4207 E.Labadie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION, SUSPECTED — INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): DIABETES MELLITUS — YEARS
DUE TO (c): 260X
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from APRIL 12, 1956 to OCT. 20, 1959 and last saw her/him alive on OCT. 13, 1959
Death occurred at 5:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. Vermillion M.D. (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 10/21/59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/24/59
23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cem.
23d. LOCATION (City, town, or county) (State): St.Louis,County, Mo.
24. FUNERAL DIRECTOR: Peoples Und.Co.
ADDRESS: 3100 Franklin Ave.
25. DATE RECD. BY LOCAL REG.: OCT 23 1959
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Tayl

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.