URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–042490

FILED VS NOV 1 9 1959

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210248 STATE FILE NUMBER

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. — b. COUNTY ~~ST LOUIS~~ 2626=A
c. CITY OR TOWN ST LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2626 – A PALM ST. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First AMELIA Middle Last SCHWEHR
4. DATE OF DEATH Month II Day – 7 Year –1959

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH Feb. 17/1876
9. AGE (last birthday) 83
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) Housework
10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE
11. BIRTHPLACE (City and state or country) MEMPHIS, TENN.
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME FREDERICH WM. DUSTMANN
13b. MOTHER'S MAIDEN NAME ANNIE SCHNEIDGER
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) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Edna Schwehr, 9241 Harnell (37) — Address

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) CA. OF UTERUS AND SIGMOID COLON — INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 199.2
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 2/14/1959, to II/7/1959 and last saw her alive on II/6/1959
Death occurred at 5. AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert A. Hall, M.D. (Degree or title)
22b. ADDRESS 3902 LAFAYETT AVE,
22c. DATE SIGNED II/8/1959

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11-9-59
23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery
23d. LOCATION (City, town, or county) St. Louis, Missouri (State)

24. FUNERAL DIRECTOR CALVIN F. FEUTZ FUNERAL HOME, ADDRESS 4828 Natural Bridge Blvd., St. Louis, 15, Missouri.
25. DATE RECD. BY LOCAL REG. NOV 9 1959
26. REGISTRAR'S SIGNATURE Earl Smith, M.D. mxB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed John A. Mlen

Licensed Embalmer No. 4186

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.