

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002743

FILED VS FEB 3 1960

273

Primary Registration District No. 3051

Registrar's No. 17

STATE FILE NUMBER

INDEXED

|  |   |   |   |  |  |   |  |
|--|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PERRY</u>  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>St. Genevieve</u>                           |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>PERRYVILLE, Mo</u>   |   | Length of stay in 1b<br><u>1 Day</u>  |   | c. CITY OR TOWN<br><u>J. R. St. Mary's</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><u>Perry Co Memorial Hospital</u>  |   |   |   | d. STREET ADDRESS (If outside, give location)<br><u>J. R. St. Mary's</u>   |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Rose</u> Middle <u>MARY</u> Last <u>Schweigert</u>   |   |   |   | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>29</u> Year <u>1960</u>  |  |   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-Feb-1890</u>                     | 9. AGE (last birthday)<br><u>69</u>  | 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><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (City and state or country)<br><u>Ozora, Mo</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME<br><u>Emile Brestler</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Josephine Siebert</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>George Schweigert</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><u>Oliver Schweigert - 5.R. St. Mary's, Mo</u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocarditis</u><br>DUE TO (b) <u>Lympho sarcoma</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days - 1 1/2 hr</u>                          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>diabetes mellitus</u>  |   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input 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 COUNTY STATE   |  |
| 21. I attended the deceased from <u>March</u> to <u>Jan 29</u> and last saw her/him alive on <u>Jan 29 1960</u><br>Death occurred at <u>Jan 29 2:40 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |   |  |  |   |  |
| 22. SIGNATURE (Degree or title)<br><u>Joseph T Lutkewitz MD</u>  |   |   |   | 22b. ADDRESS<br><u>St Mary's Mo</u>  |  | 22c. DATE SIGNED<br><u>1/31/60</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |   | 23b. DATE<br><u>2-1-60</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SACRED HEART</u> |  | 23d. LOCATION (City, town, or county) (State)<br><u>OZORA Mo</u> |   |  |
| 24. FUNERAL DIRECTOR<br><u>James A. Stauton</u>  |   | ADDRESS<br><u>St. Genevieve Mo</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>2-1-60</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Josef Zoellner</u>                                    |  |

DOCUMENT

MEDICAL CERTIFICATION

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Jerome De Santis

Licensed Embalmer No. 3817

P. O. Address. St. Eusebio

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.