RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961

-60-047911

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12295

DED

1. PLACE OF DEATH
a. COUNTY

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: 4710 Primm

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): 4710 Primm

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: WALTER Middle: E H Last: SCHWANDT

4. DATE OF DEATH: Month: December Day: 21 Year: 1960

5. SEX: male

6. COLOR OR RACE: white

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 7/11/1889

9. AGE (last birthday): 71

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): salesman

10b. KIND OF BUSINESS OR INDUSTRY: advertising

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: August Schwandt

13b. MOTHER'S MAIDEN NAME: Caroline Pottoff

14. NAME OF HUSBAND OR WIFE: Theresa

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.

17. INFORMANT: Theresa Schwandt Address: 4710 Primm

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): Cancer Prostate — INTERVAL BETWEEN ONSET AND DEATH: 3 yr

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Anemia Secondary

DUE TO (c): 177x

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 Jan 1930 to Dec 20 1960 and last saw him alive on Dec 20

Death occurred at [illegible] m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Earl C. Smith (Degree or title) MD

22b. ADDRESS: Webster Groves Mo

22c. DATE SIGNED: 12-21-60

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 12/23/1960

23c. NAME OF CEMETERY OR CREMATORY: St. Peter's Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: John L Ziegenhein & Sons ADDRESS: 7027 Gravois

25. DATE RECD. BY LOCAL REG.: DEC 22 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No. 486

P. O. Address_____

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