RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-048186

STATE FILE NUMBER

FILED VS JAN 5 1961

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3567

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton
Length of stay in 1b minutes
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute County Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ST Louis
c. CITY OR TOWN University City
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 6238 Cabanne Ave.
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First LEAH Middle ROSE Last SCHWEDT
4. DATE OF DEATH Month 12 Day 9 Year 1960

5. SEX female
6. COLOR OR RACE white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH ab. 1890
9. AGE (last birthday) ab 70
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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (City and state or country) USSR
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME (unk) Katalansky
13b. MOTHER'S MAIDEN NAME (unk)
14. NAME OF HUSBAND OR WIFE Jacob Schwedt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. Jack Enger Address 7108a Tulane Ave.

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) Unknown Natural Causes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

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 _____, to _____ and last saw her/him alive on _____
Death occurred at 3:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John C. Murphy M.D. (Degree or title) John C. Murphy, M.D. Ass't Health Comm.
22b. ADDRESS 801 S. Brentwood Clayton, Mo.
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 12-11-60
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.
23d. LOCATION (City, town, or county) University City, Mo. (State)

24. FUNERAL DIRECTOR Berger Memorial ADDRESS 4715 McPherson
25. DATE RECD. BY LOCAL REG. 12-9-60
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(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 b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No._____

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.