

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037283

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 43

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

<p>FILED SEP 17 1962</p> <p>1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u></p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u></p>		<p>Length of stay in 1b <u>LIFE</u></p>	
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>183 N. MAIN ST</u></p>		<p>d. STREET ADDRESS (If outside, give location) <u>183 N. MAIN ST</u></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>WALTER</u> Last <u>SCHWART</u></p>		<p>4. DATE OF DEATH Month <u>SEPT</u> Day <u>9</u> Year <u>1962</u></p>	
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>	
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>8/28/08</u> 64</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>TIME IND.</u></p>	
<p>11a. BIRTHPLACE (City and state or country) <u>STE. GENEVIEVE</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	
<p>13a. FATHER'S NAME <u>JOSEPH SCHWART</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>CAROLINE GRASS</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>ROSE MUESSIG</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. </p>	
<p>17. INFORMANT Address <u>17 Rose Schwegel Ste. Genevieve Mo</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u></p> <p style="text-align: center;">DUE TO (b) <u>Coronary arteriosclerosis</u></p> <p style="text-align: center;">DUE TO (c) _____</p> <p style="font-size: 8pt;">Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>			<p>INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Pulmonary Fibrosis</u></p>			<p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>			
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	
<p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>			
<p>21. I attended the deceased from <u>Aug 10</u> to <u>Sept 9</u> and last saw him alive on <u>Sept 6 1962</u> Death occurred at <u>4:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title) <u>Joseph F. Luskowitz MD</u></p>		<p>22b. ADDRESS <u>St. Genevieve, Mo</u></p>	
<p>22c. DATE SIGNED <u>Sept 10/62</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>23b. DATE <u>9/12/62</u></p>	
<p>23c. NAME OF CEMETERY OR CREMATORY <u>VALE SPRING</u></p>		<p>23d. LOCATION (City, town, or county) <u>STE. GENEVIEVE MO</u></p>	
<p>24. FUNERAL DIRECTOR <u>Les. C. Boshu St. Genevieve Mo</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>10 September 1962</u></p>	
<p>26. REGISTRAR'S SIGNATURE <u>Joseph F. Wood</u></p>			

SEP 18 1962

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

Edward J. Elbe

Licensed Embalmer No. 4740

P. O. Address St. Genevieve Mo.

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.