

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

39113

1. PLACE OF DEATH

County.....

Registration District No. **701**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City 1003**)

File No.

Registered No. **11595**

St. Ward)

2. FULL NAME: **Frank Schwartz**

(a) Residence No. **1614 Mullauply St.** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **12** yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 6 - 1883**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

46

7

20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Russia

10. NAME OF FATHER

Max Schwartz

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Poland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Poland

14. INFORMANT

(Address)

Chapman City 1003

15. FILED

NOV 19 1929

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 16 1929**

17.

I HEREBY CERTIFY, That I attended deceased from **Nov 19** 19**29** to **Nov 16** 19**29** that I last saw him alive on **Nov 20** 19**29** and that death occurred, on the date stated above, at **1250 1/2** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aneurysm of Aorta
46

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **J. Bey** M. D.

11/27 1929 (Address) **City 1003**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Alton Ill

Nov 1 1929

20. UNDERTAKER

ADDRESS

Robert W. Hudson

Alton Ill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Schwartz