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.

REC'D MAY 10 1939

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

13612
Do not use this space.

791
1003

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 3954
(c) or City St Louis (d) Street No. Mo Babtist Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Oswald
(a) Residence, No. 8540 East Gilmore St. 8
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Frank Oswald
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): October 12Th 1889
7. AGE: 49 YEARS ----- MONTHS 6 -- DAYS 15 -- If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Austria Hungaria 7

FATHER
13. NAME: Frank Glawanowitch
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Austra Hungaria 7

MOTHER
15. MAIDEN NAME: Therisa Oswald 7
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Austria Huncaria

17. INFORMANT (ADDRESS): Frank Oswald, 8540 East Gilmore
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Calvary Cemetery DATE: May 1 St 39
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Edward Koch, 3516 N 14 th St
20. FILED: APR 28 1939 J F Birdsch Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): April 27, 1939
22. I HEREBY CERTIFY, That I attended deceased from April 13., 1939, to April 27, 1939
I last saw her alive on April 27, 1939. Death is said to have occurred on the date stated above, at 2:20 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Inflamation common duct	
Subacute pancreatitis	1939

59

Other contributory causes of importance:

Diabetis mellitus	
Stone in common duct	1939
	39

Name of operation Rem. of stone Date of April 22
What test confirmed diagnosis? operatio Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Fred H Krug, M. D.
(Address) St. Louis Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1591

P. O. Address 4106 - 4 Boton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.