

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

16964

State File No. 4442

Registration District No. 791

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jewish Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days) 13 YEARS

8. (a) PRINT FULL NAME Jacob Schwartz 632

8. (b) If veteran, name war no army etc 8. (c) Social Security No. 489-05-9010

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bessie Kurtz Schwartz 6. (c) Age of husband or wife if alive (unk) years

7. Birth date of deceased June 21, 1877  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 10 27 hr. min.

9. Birthplace Roumania  
(City, town, or county) (State or foreign country)

10. Usual occupation Advertising

11. Industry or business DEPT. STORE

12. Name Solomon Schwartz

13. Birthplace Roumania  
(City, town, or county) (State or foreign country)

14. Maiden name (UNK)

15. Birthplace Roumania  
(City, town, or county) (State or foreign country)

16. (a) Informant Adolph K. Schwartz

(b) Address 710 Limit

17. (a) burial (b) Date thereof 5/19/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H. B. Berger

(b) Address 4715 McPherson

19. (a) MAY 19 1940 (b) J. F. Brudack  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town University City NR  
(If outside city or town limits, write "RURAL")  
(d) Street No. 710 Limit  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17  
year 1940 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from October  
1939, to May 17, 1940  
that I last saw him alive on May 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor  
with hemorrhages  
malignant

Due to 63c

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations as above

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 1

23. Signature Hubert G. Golewaser (M. D. or other)  
Address 634 N. Grand av Date signed 5/18/40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

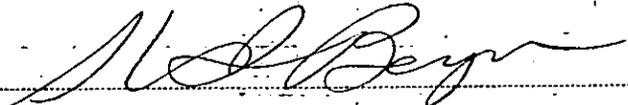
**STATEMENT BY LICENSED EMBALMER**

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. **1597**.....

P. O. Address.....

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