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1941 AUG 25 1941
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23151**

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **5596**

1. PLACE OF DEATH:

(a) County **St. Louis** **3**

(b) City or town **St. Louis**

(c) Name of hospital or institution: **St. Louis City Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days **361**

3. (a) **EDWARD SCHWITTER**
FULL NAME **EDWARD SCHWITTER**

3. (b) If veteran, name war _____ No. _____

3. (c) Social Security No. _____

4. Sex **Male** 5. Color (or) race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **February**
(Month) (Day) (Year)

8. AGE: Years **72** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **Labourer**

11. Industry or business _____

12. Name **Franklin**

18. Birthplace **"**
(City, town, or county) (State or foreign country)

14. Maiden name **"**

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

16. (a) Informant **John Stelbrad**
(b) Address **3225 Montgomery**

17. (a) **1940** (b) Date thereof **1/25/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis**

18. (a) Signature of funeral director **W. Keating**
(b) Address **3500 Cedar**

19. (a) **JUL 1 1940** (b) **J. F. Budick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____

(c) City or town **St. Louis** **11**
(If outside city or town limits, write "RURAL.")

(d) Street No. **3225 Montgomery**
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **25**
year **1940** hour **7:45** minute **0** P. M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw him alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture and dislocation of ATLAS with severance of**

Due to **old compound fracture of right leg when he was struck by a motor vehicle**

Other condition **None**
(Include pregnancy within 6 months of death)

Major findings: **Fracture of atlas and Montgomerie about 7:30 P.M. May 25-1940**

Of autopsy **Internal**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence **5/25/40**

(c) Where did injury occur? **St. Louis** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Public Place**

Where at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. F. Budick** (M. D. or other) _____
Address **Deputy**

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.....

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.