

S. No. 2
OM-2-43
Rev. 5-17-39
X356

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22508

State File No. _____

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **8868**

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

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:
Lutheran Hosp. 0
(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

3. (a) PRINT FULL NAME **Edward Schiwitz**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **2** **widower**

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

7. Birth date of deceased **Nov. 28, 1852**
(Month) (Day) (Year)

8. AGE: Years **90** Months **10** Days **7** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired Wholesale**

11. Industry or business **Bakers Supplies**

12. Name **Unknown Schiwitz**

13. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Lentz**

15. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Idea Schiwitz**

(b) Address **2808 Victor St.**

17. (a) **Burial** (b) Date thereof **10-8-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews Cem.**

18. (a) Signature of funeral director **Witt Bro. & Co.**

(b) Address **2929 S. Jefferson Av.**

19. (a) **OCT 7 1943** (Date received local registrar) **J. P. [Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** 927
(If outside city or town limits, write "RURAL")
(d) Street No. **2808 Victor St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **5**
year **1943** hour **8** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **Sept 21**
19**43**, to **Oct. 5** 19**43**
that I last saw him alive on **Oct. 5** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Hemiplegia from Cerebral
Hyperplasia - overage
Similarity
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

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

Major findings: _____
Of operations _____
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 _____
23. Signature **R. Berg** (M. D. or other) **MD.**
Address **253 Helman** Date signed **10/6/43**

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 *Gustav W. Dietrich*

Licensed Embalmer No. *4329*

P. O. Address *2929 S. Jefferson*

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, fact should be so stated above.