

FILED FEB 7 1948

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Enroute to 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 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Way

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

(d) Street No. 4615 Lindell Blvd.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Verlee Geraldine Schwarz

(b) If veteran, name war Nil

(c) Social Security No. 336-18-2888

4. Sex Female 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 October 15 1905  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

39 3 7 hr. min.

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

10. Usual occupation Assistant Buyer

11. Industry or business Stix, Baer and Fuller

MOTHER FATHER

12. Name Joseph L. Schwarz

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

14. Maiden name Stella Tibbetts

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

16. (a) Informant Joseph L. Schwarz

(b) Address Edwardsville, Ill.

17. (a) Removal (b) Date thereof 1-23-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edwardsville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 53 10 45 (b) J. F. Bruders  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22  
year 1945 hour 10:00 minute 9 22 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death Detained Hemorrhage from laceration of right Artery of heart fractured skull when she jumped from the tenth story window of the Bruders apartment 4615 Lindell Avenue to roof of garage on Jan. 22, 1945 about 9:20 P.M.

Duration \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 1604

1. Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

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) Suicide

(b) Date of occurrence Jan 22, 1945

(c) Where did injury occur 29 South Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Sub. Apt. where she made her home  
(Specify type of place)

While at work? \_\_\_\_\_ (a) Means of injury As above

23. Signature Albert H. Hoppe (M.D. or other)  
Address 4700 Washington Blvd. Date signed 1/23/48

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

APR 11 1945

OCT 31 1945

APR 9 1945

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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.....

*Albert G. Hojjes*

Licensed Embalmer No..... 2971

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, fact should be so stated above.**