

FILED MAY 7 1946

Registration District No. _____

Primary Registration District No. 5169

Registrar's No. 173

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Williamsburg Mo nine mile
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 yr
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway 14
(c) City or town Williamsburg
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Anna P. Schweitzer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F / race W
5. Color or race W
6. (a) Single, widowed, married, divorced M /
6. (b) Name of husband or wife John N. Schweitzer
6. (c) Age of husband 71 years if alive Feb 20 th 1882
7. Birth date of deceased (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>2</u>	<u>10</u>	hr. _____ min. <u>0</u>

9. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER {
12. Name Richard D. Alpers
13. Birthplace Germany (City, town, or county) (State or foreign country) 4
14. Maiden name Anna M. Schweitzer
15. Birthplace Germany (City, town, or county) (State or foreign country) 4

16. (a) Informant John N. Schweitzer
(b) Address Williamsburg Mo

17. (a) Burial (b) Date thereof May 4 th 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem St Louis Mo

18. (a) Signature of funeral director C. W. Hopkins
(b) Address Montgomery City Mo

19. (a) May 1, 1946 (b) Jesse Morsink
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30 -
year 1946 hour 3 minute 55 A.M.

21. I hereby certify that I attended the deceased from April 30
1946 to April 30, 1946
that I last saw her alive on April 30, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Due to Hypertension
Due to _____

Duration 1 hr.
1 yr.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 940

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) _____
(b) Date of occurrence _____

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 James O. Helm (M. D. or other) 1
Address New Florence Mo Date signed 4-30-46

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-8-46

JUL 31 1957

MAY 12 1946

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, my on the 30
day of April 1946

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

C. W. Hopkins

Licensed Embalmer No. 1487

P. O. Address Montgomery City Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 47Primary Registration District No. 5169Registrar's No. 173

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Willapark
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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

Anna P. Schweitzer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Feb. 20
(Month) (Day) (Year)8. AGE: Years 64 Months _____ Days _____ (If less than one day) _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. 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 _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 1st 1946 (b) Josie M. M. Hoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 Hour _____ minute _____ M.

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

that I last saw him/her alive on _____, 19____;

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

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

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) _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

12446