

No. 2
5-43
5-17-39
I X36671

FILED NOV 8 1946

Registration District No. _____

Primary Registration District No. 1003

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:
Enroute 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 52 Yrs 6 Mon. 18 Days
years, months or days)

3. (a) PRINT FULL NAME Katherine Schwart

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

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

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

7. Birth date of deceased 4 6 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 6 18 hr. min.

9. Birthplace St. Louis Mo. (1)
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Ignatius Goldman 4

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

14. Maiden name Mary Hoppe

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

16. (a) Informant Marie Schwart

(b) Address 2225 N Market St.

17. (a) Burial (b) Date thereof 11 -8-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (d) Signature of funeral director Donald Goodhart

(b) Address 2228 St. Louis Ave.

19. (a) NOV 6 1946 (b) J. F. Ruedek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 26 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2225 N Market St. 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 4
year 1946 hour 10 minute 30p M.

21. I hereby certify that I attended the deceased from
10-18 1946 to 11-4 1946
that I last saw h. aw alive on 10-29 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage
Due to arteriosclerosis
Due to Essential Hypertension
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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?

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

23. Signature J. F. Ruedek (M. D. or other) _____
Address 3804-714th Date signed 11-5-46

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 *Marie A. Cashion*
Licensed Embalmer No. *3949*
P. O. Address. *St. Louis 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.