

No. 2
-1/47
-17-39

National Office of Vital Statistics

FILED MAY 15 1948

Registration District No. **318**

Primary Registration District No.

1003

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: **St. Anthony Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 days**
(Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4258 Beck Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

100
17
9
0

3. (a) PRINT FULL NAME **Della Schwarz**

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 **Married**
6. (b) Name of husband or wife **Arthur F.** 6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **Feb. 14 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70² 2 2 hr. min.

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

10. Usual occupation **Home**

11. Industry or business

12. Name **Unknown Murphy**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Arthur F. Schwarz**

(b) Address **4238 Beck Ave.**

17. (a) Burial (b) Date thereof **5/8/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Resurrection Cemetery**

18. (a) Signature of funeral director **Wacker-Wilde**

(b) Address **3634 Gravois Ave.**

19. (a) **MAY 7 1948** (b) **J. F. Bredek**
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **5**
year **1948** hour **5** minute **45** P.M.

21. I hereby certify that I attended the deceased from **April 24**
1948, to **May 5** **1948**
that I last saw **her** alive on **May 5** **1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** Duration **40 hours**

Due to **Chronic Myocarditis** **2 years**
Atherosclerosis **2 years**

Due to **Hypertension** **2 years**

Other conditions **Gangrenous Appendicitis** **8 days**
Include pregnancy (within months of death)
Appendicitis

Major findings: **Gangrenous Appendix**
Of operations: **Pneumonia**

Of autopsy:

Duration
PHYSICIAN
Underline the cause of 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)

(c) Means of injury.....

23. Signature **Francis J. Whail** (M. D. or other) **M.D.**

Address **5207 Chippewa** Date signed **May 6 1948**

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

MOTHER FATHER

Handwritten scribble

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..... *Frank J. Island*

Licensed Embalmer No. *2675*

P. O. Address..... *Louisiana*

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.