

No. 300  
10-47  
5-17-39  
PI 3908

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED AUG 12 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 24697  
Registrar's No. 6845

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jewish Hos'p  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days (Specify whether  
In this community abt 3 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0017  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1615 Lindell Blvd  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME ANNA HEARSH SCHWARTZ

3. (b) If veteran, name war \*\*\*\*\* 3. (c) Social Security No. 560-28-2995

4. Sex Female 5. Color or race W.  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife. David Schwartz  
6. (c) Age of husband or wife if alive 47 years  
7. Birth date of deceased. November 24 1901  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>8</u>	<u>9</u>	hr. min.

9. Birthplace Jersey City N.J.  
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

12. Name Isaac W. Schwartz

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

14. Maiden name Tillie Shapiro

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

16. (a) Informant David Schwartz

(b) Address 4615 Lindell Blvd

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

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell

19. (a) AUG 4 - 1948 (b) J. Budeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3  
year 1948 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 31 to Aug 3, 1948  
that I last saw her alive on Aug 3, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism Duration 1 day

Due to Pharyngeal abscess with mitral stenosis 174M

Due to \_\_\_\_\_

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

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) Means of injury (C)

23. Signature Arthur E. Straub (M. D. or other)

Address 532 N Grand Date signed 8/3/48

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

MOTHER FATHER

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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 *Robert M. Murray*

Licensed Embalmer No. *3749*

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.**