

FILED AUG 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28649

State File No. 27072

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (In this place) 57 da		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,				d. STREET ADDRESS (If rural, give location) 4915 Lindell, Blvd			
3. NAME OF DECEASED (Type or Print) a. (First) OTTO		b. (Middle) HENRY		c. (Last) SCHWARZ		4. DATE OF DEATH (Month) (Day) (Year) AUG 19, 1950	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M /		8. DATE OF BIRTH 6/15/1888	
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months		IF UNDER 2 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) St Louis	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Dr Henry Schwarz			13b. MOTHER'S MAIDEN NAME Johanna Forster			14. NAME OF HUSBAND OR WIFE May Vivian Rowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rose Schwarz - 4915 Lindell			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc.: It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-esophageal fistula ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Esophagus DUE TO (c) None II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH 2 months 1 year	
19a. DATE OF OPERATION Dec 3, 49		19b. MAJOR FINDINGS OF OPERATION Gastrostomy				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR? 150X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 7-1-50 to 8-19-50 , that I last saw the deceased alive on 8-19-50 , and that death occurred at 7:30 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE Richard M. Peters M.D.				23b. ADDRESS Barnes Hospital,		23c. DATE SIGNED 8/19-50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Aug 21st		24c. NAME OF CEMETERY OR CREMATORY St Peters Cemetery		24d. LOCATION (City, town, or county) (State) St Louis County	
DATE REC'D BY LOCAL REG. AUG 2 1950		REGISTRAR'S SIGNATURE J. B. Sauter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arthur J. Donnelly, 3840 Lindell			

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

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 _____

_____, Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Thomas R. Fenwick

Licensed Embalmer No. 3793

P. O. Address 3840 Lindell

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.