

Health,
Welfare
Public
Service

FILED APR 9 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012290

STATE FILE NUMBER 3777

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits <u>2129</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Res. Westgate Hotel</u>		Length of stay in 1b <u>5yrs</u>	
d. STREET ADDRESS <u>706 N. Kingshighway Westgate Hotel</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl Alfred Schwartz</u>			4. DATE OF DEATH Month Day Year <u>April 3, 1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1896</u>
9. AGE (In years last birthday) <u>61yrs</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter St. Lukes Hospital</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Robert J. Schwartz</u>	
13b. MOTHER'S MAIDEN NAME <u>Marie Scannell</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-1</u>		16. SOCIAL SECURITY NO. <u>497-10-2581</u>	17. INFORMANT Address <u>Mr. Robert R. Schwartz Westgate Hotel</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE BRONCHOPNEUMONIA, BILATERAL</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA</u>			<u>4-6 YRS.</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>527.1</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>2</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>1955</u> to <u>7/3/58</u> and last saw <u>him</u> alive on <u>7/3/58</u> Death occurred at <u>5:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William A. Fung M.D.</u>		22b. ADDRESS <u>3720 WASHINGTON</u>	22c. DATE SIGNED <u>7/9/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 4, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Alexander & Sons 6175 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>APR 4 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>S.P.</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

Wm. C. H. S.

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
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *2460*

P. O. Address *6175 Palm*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.