

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 1 3 2

FILED VS DEC 23 1959

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 301

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<u>Saint Charles</u>	a. STATE	<u>Missouri</u> COUNTY <u>St. Charles</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	<u>Saint Charles</u>	c. CITY OR TOWN	<u>Saint Charles</u>
Length of stay in 1b		Inside Limits	
<u>28 yrs.</u>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	<u>209 McDonough</u>	d. STREET ADDRESS (If outside, give location)	<u>209 McDonough</u>
Inside Limits		Reside on Farm	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	<u>David</u>	<u>B.</u>	<u>Schwendemann</u>	<u>Dec. 17, 1959</u>			

5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
<u>Male</u>	<u>White</u>		<u>Dec. 30, 1893</u>	<u>65</u>	Months <u>11</u> Days <u>17</u>	Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<u>cabinet maker</u>	<u>retired</u>	<u>Saint Peters, Mo.</u>	<u>U.S.A.</u>

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<u>John Schwendemann</u>	<u>Caroline Fetsch</u>	<u>Hattie Seeler</u>

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 Address
<u>No</u>	<u>493-03-5780</u>	<u>Mrs. D.B. Schwendemann, St. Chas., Mo</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Myocardial Infarction</u>	<u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	<u>Coronary Arteriosclerosis</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)	PART III. If deceased was female was there a pregnancy in last 90 days.
<u>Generalized arteriosclerosis</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour <u></u> s.m. <u></u> p.m. <u></u>	Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK <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 1938 to Dec 17-59 and last saw him alive on Nov 23-57
 Death occurred at 6 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
<u>Vincent A. Schuman MD</u>	<u>St. Charles, Mo</u>	<u>12-18-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec. 21, 1959</u>	<u>St. Peters Cemetery</u>	<u>Saint Charles, Mo.</u>

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>H.C. Dallmeyer & Sons, St. Charles, Mo</u>	<u>Dec 18-59</u>	<u>Marguerite Wilson</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Francis R. Amalson

Licensed Embalmer No. *483*

P. O. Address

N. Charles

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.