

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS JAN 16 1961

318

1003

26761-003651

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 26761-003651

| | | | | | | | | | |
|---|------------------------------|---|--|---|---|--|--|--------|-------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <i>St. Louis</i> | | Length of stay in 1b | | c. CITY OR TOWN <i>St. Louis</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <i>Desloge Hospital</i> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <i>3745 Indell Blvd</i> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>RUTH Eugenia SCHWARZ</i> | | | | 4. DATE OF DEATH Month Day Year <i>Jan. 8th. 1961</i> | | | | | |
| 5. SEX <i>F.</i> | 6. COLOR OR RACE <i>W</i> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>2/22/1909</i> | 9. AGE (last birthday) <i>51</i> | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secy. St. L. U. School of Medicine</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTH PLACE (City and state or country) <i>St. Louis, Mo</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.</i> | | | |
| 13. FATHER'S NAME <i>F. Gottlieb Schwarz</i> | | | 13b. MOTHER'S MAIDEN NAME <i>M. Hildegard Sack</i> | | 14. NAME OF HUSBAND OR WIFE <i>Milian R. Schwarz, 1327 Veronica</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Milian R. Schwarz, 1327 Veronica</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EMBOLISM (CLINICAL IMPRESSION)</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> DUE TO (b) <i>METASTATIC CARCINOMA - LIVER</i> <i>4 wks</i> DUE TO (c) <i>CARCINOMA OF BREAST - LEFT.</i> <i>10 months</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chronic nephritis - hypertension</i> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <i>170X</i> | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 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 <i>1-3-61</i> to <i>1-8-61</i> and last saw her alive on <i>1-8-61</i> . Death occurred at <i>1:15 P.m</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <i>C. Rollins Houlgan M.D.</i> (Degree or title) | | | | 22b. ADDRESS <i>1325 S. GRAND BLVD St. Louis</i> | | 22c. DATE SIGNED <i>1/8/61</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>1/11/1961</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i> | | | |
| 24. FUNERAL DIRECTOR <i>Arthur Monnells, 3840 Indell Blvd</i> | | | | 25. DATE RECD. BY LOCAL REG. <i>JAN 10 1961</i> | | 26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> | | | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 AFFIDAVIT OF

APR 28 1961

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 D. Williamson

Licensed Embalmer No.

3565

P. O. Address

3840 Lindal

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.