

No. 2  
1-2-43  
5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40620

FILED DEC 29 1943

State File No. \_\_\_\_\_

Registration District No. 1318

Primary Registration District No. 1003

Registrar's No. 10963

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Masonic Home of Missouri 5  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks

In this community same (Specify whether years, months or days)

3. (a) PRINT FULL NAME Louis Swarts

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Sophia 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan. 14, 1869  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74	10	25	_____ hr. _____ min.
----	----	----	----------------------

9. Birthplace Chillicothe, Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

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

MOTHER FATHER

12. Name Samuel Swarts

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Rose Stern

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Rothe

(b) Address 5351 Delmar Blvd.

17. (a) Burial (b) Date thereof 11-12-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Hermon Lindsey

(b) Address 2316 E. Lamar

19. (a) DEC 11 1943 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri California 999  
(b) County

(c) City or town St. Louis Los Angeles, D.C.  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9th  
year 1943 hour Nine minute 40 P. M.

21. I hereby certify that I attended the deceased from November 21st, 1943, to Dec. 9th, 1943;  
that I last saw him alive on November 29th, 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis 2 days  
from Chl Myocarditis

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

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

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

(e) Means of injury \_\_\_\_\_

23. Signature John Samuelson 0 (M. D. or other)

Address 508 No. Grand Date signed 12-9-43

WRITE PLAINLY—USE 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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *William Hiron*  
Licensed Embalmer No. *5216 Debnar*  
P. O. Address *4319*

**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.**