

S. No. 2
M-5-43
5-17-39
I X36671

22930
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1905

5797

State File No.

FILED MAR 1 1944
Registration District No.

Primary Registration District No.

Registrar's No. 1653

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County.....

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

(d) Street No. 5067 a WINONA
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME John Swerdfeeger

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWER

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

7. Birth date of deceased Aug 22 1862
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month / Feb. day 17th year 1944 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 28th 1944, to Feb. 17th, 1944.
that I last saw h. in alive on Feb. 17th 1944, and that death occurred on the date and hour stated above.

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

81 5 26 hr. min.

Immediate cause of death Peripheral Circulatory Collapse

Due to Senile Psychosis
Generalized arteriosclerosis - aqumie 14
Disuse

Duration

9. Birthplace ILL. I.
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

11. Industry or business.....

12. Name Unknown

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

14. Maiden name "

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

Other conditions (include pregnancy within 3 months of death) 95

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Dona Bergman
(b) Address 5067 a Winona

17. (a) Burial (b) Date thereof 2-19-44
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director E. J. Schuer
(b) Address 3125 Lafayette Ave

19. (a) FEB 19 1944 (b) G. J. Brueck
(Date received local registrar) (Registrar's signature)

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 Wes D. Mad (P. D. or other) 2/17/44
Address 1515 Lafayette Date signed.....

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.....

Joseph Bolmer

Licensed Embalmer No. *4014*

P. O. Address. *Houston, Mo.*

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.