V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 12520
Registrar's No. 1517

Registration District No. 149 Primary Registration District No. 1002

**1. PLACE OF DEATH:**

(a) County Jackson,
(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1811 Myrtle Conv. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mos (Specify whether
In this community 50 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson, 48
(c) City or town Kansas City 5
(If outside city or town limits, write "RURAL") 8
(d) Street No. 5941 Paseo
(If rural, give location)
(e) Citizen of foreign country? no. 0 (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME Miss Mollie Swartz

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

4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Single 6
6. (b) Name of husband or wife x
6. (c) Age of husband or wife if alive x years
7. Birth date of deceased February (Month) 24 (Day) 1868 (Year)

8. AGE: Years 77 Months 1 Days 8 If less than one day hr. min.

9. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name Adam D. Swartz
13. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah E. Ishler
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Fred Mileham,
(b) Address 5941 Paseo, Kansas City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Hope Cemetery
18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 4-4-45 (Date received local registrar) (b) S. Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April March day 2
year 1945 hour minute P. M.

21. I hereby certify that I attended the deceased from December 20, 1945, to April 2, 1945;
that I last saw her alive on April 2, 1945;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death lobar | |
| Hypostatic Pneumonia | 3-31-45 |
| Myocarditis with Decompensation | 12-24-44 |
| Due to Cerebral Hemorrhage | 12-20-44 |
| Due to Arteriosclerosis et Compensating Myocarditis | years |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations 108
Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury 2

23. Signature Dr. Nelson Myers (M. D. or other) D.O.
Address 612 Chambers Bldg K. C. Mo. Date signed 4-3-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Nelson Myers
Chambers Bldg

9321

## 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 [signature]

Licensed Embalmer No. 1415

P. O. Address K C M

**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.**