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FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35631

BIRTH NO. #96872 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8849

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Mo.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission):
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS
d. STREET ADDRESS (If rural, give location) 3916 GARFIELD

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) R. c. (Last) SWAIN
4. DATE OF DEATH (Month) (Day) (Year) Oct. 14th, 1949
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 1/26/1884
9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN
10b. KIND OF BUSINESS OR INDUSTRY CARTER CARB.
11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME CHARLES A. SWAIN
13b. MOTHER'S MAIDEN NAME KATERINE EAGAN
14. NAME OF HUSBAND OR WIFE ADELAIDE SWAIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME ADDRESS ADELAIDE SWAIN, 3916 GARFIELD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/19/49, 19___, *to* 10/14/49, 19___, *that I last saw the deceased alive on* 10/14/49, 19___, *and that death occurred at* 5:35am *m., from the causes and on the date stated above.*

23a. SIGNATURE Aaron Heidin M.D. (Degree or title)
23b. ADDRESS 1515 Lafayette Ave.,
23c. DATE SIGNED 10/14/49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 10/17/49
24c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES CEM
24d. LOCATION (City, town, or county) (State) ST. LOUIS CO., MO.

DATE REC'D BY LOCAL REG. OCT 14 1949
REGISTRAR'S SIGNATURE L. B. Sasate
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 N. GRAND

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

_____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.