

FILED MAR 7 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6796

State File No. 1837  
Registrar's No. 1003

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>1003</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>42 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo. 22-9</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1811 Warren St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>L</u> c. (Last) <u>Swales</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2 23 51</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-11-'95</u>		9. AGE (In years last birthday) <u>55</u> # UNDER 1 YEAR _____ # UNDER 1 MONTH _____ # UNDER 1 DAY _____ # UNDER 1 HOUR _____ # UNDER 1 MIN. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri PAISCOLA</u>		12. CITIZEN OF WHAT COUNTRY? _____
13a. FATHER'S NAME <u>John Swales</u>			13b. MOTHER'S MAIDEN NAME <u>Rebecca Hamand</u>		14. NAME OF HUSBAND OR WIFE <u>Johanna Swales (Pope)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes #1</u>			16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Johanna Swales 1811 Warren St.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial asthma</u> ANTECEDENT CAUSES <u>Chronic Emphysema</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u> <u>15 yrs</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>241X</u>			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>48</u> , to <u>Feb 23</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>51</u> , and that death occurred at <u>3:49 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert M. Louch M.D.</u>				23b. ADDRESS <u>De Paul Hospital</u>		23c. DATE SIGNED <u>14, 1951</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-26-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Co</u>		
DATE REC'D BY LOCAL OFFICE <u>FEB 24 1951</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Godhart &amp; Goodhart 2228 St. Louis Av</u>			

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

*Mail*

MAR 7 1951

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 *John J. Haines*  
Licensed Embalmer No. *4108*

P. O. Address *St Louis 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.