

FILED MAR 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10695
Registrar's No. 2168

BIRTH NO. 19179-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. d. STREET ADDRESS (If rural, give location) 2126 Obear Ave	
3. NAME OF DECEASED a. (First) Faith b. (Middle) c. (Last) Swanson		4. DATE OF DEATH (Month) (Day) (Year) 3 6 51	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child 0	
8. DATE OF BIRTH 3-4-51		9. AGE (In years last birthday) IF UNDER 1 YEAR 1 MONTHS IF UNDER 12 HOURS 12 MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Morris Swanson		13b. MOTHER'S MAIDEN NAME Alice Frohman	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mr Morris Swanson ADDRESS 2126 Obear Av	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus ANTECEDENT CAUSES Erythroblastosis fetalis 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. Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		770.3	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at 8:30A m., from the causes and on the date stated above.			
23a. SIGNATURE Thomas Wilson (Degree or title)		23b. ADDRESS 600 N Grand	
23c. DATE SIGNED		24a. BURIAL CREMATION, REMOVAL (Specify) Burial	
24b. DATE 3-7-51		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Co.		25. FUNERAL DIRECTOR'S SIGNATURE Goodhart & Goodhart ADDRESS AV 2228 St. Louis	
DATE REC'D BY LOCAL REG. MAR 7 1951		REGISTRAR'S SIGNATURE J. B. Laster	

Not Embalmed

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Goodhart & Goodhart.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.