

6-5-59  
Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016087  
STATE FILE NUMBER

FILED MAY 7 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1062

300  
1-57  
38  
595  
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1. PLACE OF DEATH a. COUNTY <b>ST. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis (12)</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Co. Hosp. DOA</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>5479 Enright Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY - LOUISE ROSVALL SWAINE</b>			4. DATE OF DEATH Month Day Year <b>April 17, 1959</b>		
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5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1910</b>	9. AGE (In years last birthday) <b>48</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Peter Rosvall</b>	13b. MOTHER'S MAIDEN NAME <b>Hulda</b>	14. NAME OF HUSBAND OR WIFE <b>William Godfrey Swaine</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT Address <b>William G. Swaine 5479 Enright (12)</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents with suffocation due to laryngospasm and obstruction of the tracheo bronchial tree</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <b>Natural Causes</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Natural disease process</b>
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20c. TIME OF INJURY <b>4:14 P.m. body found</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>motel</b>	20e. CITY, TOWN, OR LOCATION <b>Creve Coeur St. Louis Missouri</b>
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20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20g. CITY, TOWN, OR LOCATION <b>Creve Coeur St. Louis Missouri</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Raymond H. ... Coroner</b>	22b. ADDRESS <b>Clayton, Mo.</b>	22c. DATE SIGNED <b>4/23/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>April 20, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>4-20-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, Md</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *jos. E. McCullough* .....

Licensed Embalmer No. *2467* .....

P. O. Address *612 5th St* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.