

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS FEB 25 1960**

2 1798 STATE FILE NUMBER **60-008948**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>MISSOURI</b>	b. COUNTY
Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</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 MARY INFIRMARY</b>		d. STREET ADDRESS (If outside, give location) <b>1345 Leffingwell</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Finley</b> Middle <b>SWIFT</b> Last			4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</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>1-15-14</b>	9. AGE (last birthday) <b>45 YRS</b>	IF UNDER 1 YEAR Months <b>28</b> Days	IF UNDER 24 HR Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUTCHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KREY PKG.</b>		11. BIRTHPLACE (City and state or country) <b>WEST POINT MISS. U.S.A</b>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <b>JAMES SWIFT</b>		13b. MOTHER'S MAIDEN NAME <b>VIOLA HOUSE</b>		14. NAME OF HUSBAND OR WIFE <b>ANNIE SWIFT</b>		
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. <b>---</b>		17. INFORMANT <b>Annie Swift 1345 Leffingwell</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		
DUE TO (b) <b>Hypertension</b>		
DUE TO (c)		<b>331X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm; factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>9th Feb</b> to <b>17th Feb</b> and last saw her/him alive on <b>17th Feb</b> Death occurred at <b>10:00 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <b>M. Beaton</b> (Degree or title)	22b. ADDRESS <b>2500 Washington</b>	22c. DATE SIGNED <b>2/18/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>2-18-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD Cem. Wellston Mo.</b>
24. FUNERAL DIRECTOR <b>A.F. WAITER</b> ADDRESS <b>2707 Stoddard</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 16 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**74813**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*H. C. Lande*

Licensed Embalmer No. 3418

P. O. Address 17237

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.