

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8001

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1193
 Township Shannon Primary Registration District No. 1003 Registered No. 1193
 City St. Louis (No. 3500 6 30th St.) St. Ward

2. FULL NAME

James Swanson
 (a) Residence No. 3500 E 27th St., Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-8-1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 2 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) none
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis City, Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Howard Swanson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Meout City, Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Betty Turner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Keokuk City, Mo
 (STATE OR COUNTRY)

14. INFORMANT Joseph Turner
 (Address) 3500 E 27th

15. FILED 4/17/25 19 25 M. M. Carrow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-16 19 25

17. I HEREBY CERTIFY That I attended deceased from 3/14/25 mor. 4 1925, to mor. 16 1925, that I last saw him alive on mor. 16 1925, and that death occurred, on the date stated above, at 5-03 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
11 Broncho-Pneumonia
12
11a
 (duration) yrs. mos. ds. 12 ds.

CONTRIBUTORY (SECONDARY) Influenza
 (duration) yrs. mos. ds. 20 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: not known

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) W. Woodwell, M. D.

3/17/25 (Address) 2432 Olive

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Funeral Home DATE OF BURIAL 3-17 19 25

20. UNDERTAKER Funeral Home ADDRESS

