

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

Do not use this space
9761

1. PLACE OF DEATH

County..... Registration District No..... **791**
Township..... Primary Registration District No..... **1003**
City **St. Louis, Mo.** (No. **City Dep. No. 2**)

File No.....
Registered No. **2317**
St. Ward)

2. FULL NAME

(a) Residence. **Jerry William Swift**
1013 No 71 St., **25** Ward.
Length of residence in city or town where death occurred **10** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male.** 4. COLOR OR RACE **negro.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) **Single.**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known.**
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 30 | — | — | — | —

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Lawyer**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER **Josephus Swift**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis**
12. MAIDEN NAME OF MOTHER **Anna Edwards**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

14. INFORMANT (Address) **Chas. F. Woodard**
City Hospital #2

15. FILED **May 6 1927**
May 6 Starrcoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar 3 - 1927**
17. I HEREBY CERTIFY, That I attended deceased from **Feb 29**, 19**27** to **March 3**, 19**27**, that I last saw him alive on **March 3**, 19**27** and that death occurred, on the date stated above, at **3:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
Chronic hepatitis
Indefinite

18. WHERE WAS DISEASE CONTRAICTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? **Chemical Laboratory**
(Signed) **J. W. Gray**, M. D.
3/4, 19**27** (Address) **City Dep No 2**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood** DATE OF BURIAL **3-8-1927**

20. UNDERTAKER **W. S. Wade & Co** ADDRESS **4202 Finney Ave**

WWW.CHANGING INK---THIS IS PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

