

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

Do not use this space.

8994

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township East

Primary Registration District No. 1002

City Jackson

(No. 3900 E - 13th St.)

File No. 1007

Registered No. 1007

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3900 - E - 13th St., _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-9-27

7. AGE: YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
- 6 6 -

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) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Chas. Swape

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Bertha Clary

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

14. INFORMANT Charles Swape (Address) 3900 - E - 13th St.

15. FILED 3.15.28 M. M. Crane REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March-15-1928

17. I HEREBY CERTIFY, That I attended deceased from Mar. 14/1928 to Mar. 14, 1928, that I last saw him alive on Mar. 14, 1928, and that death occurred, on the date stated above, at 8:15 Am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

CONTRIBUTORY four Day Exposure (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? # 1000 1st Place of Death IF NOT AT PLACE OF DEATH? no

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical (Signed) Frank E. Day, M. D.

(Address) 4848 Montrose Ave

*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 Eyebair Sp. Mo. DATE OF BURIAL March 15/28

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K.C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A 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.

