

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

Do not use this space.

✓ 35951
File No. 11063
Registered No. 11063
St. _____ Ward)

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **St. Louis** (No. **1224 Dillon St.**)

2. FULL NAME

Robert Swan
(a) Residence. No. **1224 Dillon St** St., **22** 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) Infant		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown				
7. AGE YEARS abt	MONTHS 3 Mo	DAYS	IF LESS than 1 day, hrs. or min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... Child (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) **Missouri**

10. NAME OF FATHER **Robert Swan**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Loraine Wathen**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. INFORMANT. **John J. Hurley**
(Address) **Zookeepers Office**

15. FILED. **NOV 13 1929**
19. **May C. Hamblin** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10/28 1929**

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... **5:30 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
Primary
10/28 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **10/28** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY? **ye.**
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **J. W. Kerne**
11/5 1929 (Address) **Dep. Coroner**
*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 **Coller Field** DATE OF BURIAL **11/3 1929**

20. UNDERTAKER **Zeegehans Bros** ADDRESS **2621 Cherokee**

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.

