

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

Do not use this space

39723

PLACE OF DEATH

County Buchanan Registration District No. 85
Township Washington Primary Registration District No. 1001
City St. Joseph (No. State Hospital #2) St. _____ Ward _____

File No. _____
Registered No. 1401

2. FULL NAME Martin J. Swade
(a) Residence No. State Hosp. #2 St. Hoop Ward _____
(Usual place of abode)
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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widower</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 23 1844</u>				
7. AGE	YEARS <u>83</u>	MONTHS <u>8</u>	DAYS <u>15</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (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) W. Virginia

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT St. Joe Hosp #2 records
St. Joseph
15. FILED 1929
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 8 1929
17. HEREBY CERTIFY, That I attended deceased from April 1 1929 to Dec 8 1929 that I last saw him alive on Dec 8 1929 and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
10/10/10
CONTRIBUTORY (SECONDARY) Senility
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) [Signature] M. D.
12-8-1929 (Address) State Hospital #2 St. Joseph

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Marshall Mo DATE OF BURIAL Dec 8 1929
20. UNDERTAKER E. R. Eidenfaden ADDRESS 602 So. 10

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. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

102677

1
2

