

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

Do not use this space.

14567

**1. PLACE OF DEATH**

County..... Registration District No.....  
 Township..... Primary Registration District No. 791  
 City St. Louis (No. Home of Ag 1003) Registered No. 3917  
 St. .... Ward)

**2. FULL NAME**

George Swingle  
 (a) Residence. No. 2209 Hebert St., 20 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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 13th 1862</u>		
7. AGE <del>67</del> YEARS	MONTHS	DAYS
<u>67</u>	<u>7</u>	<u>5</u>
8. OCCUPATION OF DECEASED <u>Stationary</u> (a) Trade, profession, or particular kind of work <u>Station Engineer</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN); Chicago  
 (STATE OR COUNTRY) Ill

10. NAME OF FATHER <u>Henry Swingle</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN); (STATE OR COUNTRY) <u>Unknown</u>
12. MAIDEN NAME OF MOTHER <u>Catherine Britts</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT Sister Jeanne  
 (Address) 2209 Hebert St

15. FILED 20 1930 Max C. Stakley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 18th 1930  
 17. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to April 18, 1930 that I last saw him alive on April 17, 1930 and that death occurred, on the date stated above, at 6:30 A.M. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Hemorrhage (Apoplexy)  
82A  
97 / 4 (duration) yrs. mos. 4 da.  
 CONTRIBUTORY (SECONDARY) Arteriosclerosis  
 (duration) yrs. mos. da.

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 Examination  
 (Signed) Anthony A. Bekirakis, M. D.  
4/18, 1930 (Address) 15252 Cass 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 Calvary Cemetery DATE OF BURIAL 4/21 1930

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St

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.

