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

Do not use this space.

42625

File No. 12543

Registered No. 12543

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 2613 Lawton St. ..... Ward)

2. FULL NAME Madison Swope

(a) Residence. No. 2613 Lawton St., 21 Ward. (If nonresident, give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Colord	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lula

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1870

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
about	60			

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

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Miss

PARENTS

10. NAME OF FATHER Madison Swope Sr.

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

12. MAIDEN NAME OF MOTHER Emily Wilson

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

14. INFORMANT Ellen Humphy
(Address) 2613 Lawton

15. FILED ..... 19 ..... Max C Hardy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/16 1931

17. I HEREBY CERTIFY, That I attended deceased from 9/22, 1931, to 11/28, 1931, that I last saw him alive on 11/28, 1931, and that death occurred, on the date stated above, at 3 am. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency.

924 (duration) ..... yrs. ..... mos. 67 ds.

CONTRIBUTORY (SECONDARY) [signature] (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? .....

(Signed) [signature], M. D.

, 19 (Address) 214 Peoples Bldg

*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	DATE OF BURIAL
Calvary Cem	Dec 21 1931
20. UNDERTAKER	ADDRESS
J W Hughes	2620 Lawton

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.