

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

Do not use this space.

16946

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Keosauqua Primary Registration District No. _____
 City Kansas City (No. 2143 6-8) St. _____ (Ward) _____

File No. _____
 Registered No. _____

2. FULL NAME

Lee Anthony Swircinski
 (a) Residence, No. 2143-6-8 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. 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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9-1895

7. AGE YEARS 39 MONTHS 1 DAYS 11 If LESS than day, h or m

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Cabinet Maker

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

FATHER 13. NAME Paul Swircinski

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Clara Kazak

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Paul Swircinski

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Washington DATE May 24 1934

19. UNDERTAKER (ADDRESS) A. C. Doehler

20. FILED May 25 1934 M. M. Crane Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5 20 34, 19

22. I attended deceased from _____, 19

I last saw him alive on 1 4 34 Death is said

to have occurred on the day stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Acute infectious disease
pharyngitis
96

Other contributory causes of importance:

Name of operation _____ Date _____

What test confirmed diagnosis _____ Was there an _____

23. If death was due to external causes violence, All in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) [Signature], M. D.
 (Address) [Address]

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. JUN 19 1934

