

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

6573
Do not use this space.

1. PLACE OF DEATH

(a) County Gasconade Registration District No. 304
 (b) Township 1 Primary Registration District No. 5421 Registered No. 39
 (c) City Gasconade or (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred 9 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

632 Charles Frederick Swartz
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
Gasconade, Missouri
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 27, 1894

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
45 6 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 9. Industry or business in which work was done, as 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) Chicago, Illinois
 (STATE OR COUNTRY)

13. NAME Frederick Swartz

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

15. MAIDEN NAME Unkown

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

17. INFORMANT Mrs. Elizabeth Swartz
 (ADDRESS) Gasconade, Missouri

18. BURIAL, CREMATION, OR REMOVAL Gasconade City Cem. 3/1/40
 PLACE DATE

19. FUNERAL DIRECTOR (NAME) Hugo H. Blumer
 (ADDRESS) Hermann, Missouri

20. FILED 3/4 1940 J. S. Kiser
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/28/40, 19__

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Coroner's Verdict of Jury:
Came to his death by shooting himself.

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill 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 CO. Bunge Coroner D.
 (Signed) _____
275 (Address) Bland, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A FEDERAL REQUIREMENT. 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.

195-
99

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Herbert Blumenthal

Licensed Embalmer No. 3160

P. O. Address Herzmann Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **65-73**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **304**

Primary Registration District No. **5421**

Registrar's No. **59**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Gasconade**

(b) City or town **Richland Twp**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)

years, months or days

3. (a) PRINT FULL NAME **Charles Frederick Swartz**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years **45** Months **6** Days **1** If less than one day _____

9. Birthplace (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **28** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that last saw him _____ alive on _____ 19____

and that death occurred on the date and hour stated above.

Immediate cause of death **gun**

Coroner's Verdict

He **came to his death by**

shooting himself

suicide

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **167**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) _____ (e) Means of injury _____

23. Signature **E. A. Byrge** (M. D. or other) _____

Address **Bland Mo** Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

