S. No. 2
0M—2-43
v. 5-17-39
P-1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 26 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15640

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4278

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
enroute City Hospital ?
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis.
(If outside city or town limits, write "RURAL")

(d) Street No. 648 Tower Grove Av.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas Swantner

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rubye

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased Unknown (Month) About (Day) 1872 (Year)

8. AGE: Years Abt 73 Months Unknown Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Swantner
13. Birthplace Czechoslovakia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Rubye Swantner
(b) Address 648 Tower Grove Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/45 (Month) (Day) (Year)
(c) Place: burial or cremation Old S.S. Peter&Paul

18. (a) Signature of funeral director Wm. E. Mrydue
(b) Address 1926 Allen Av.

19. (a) MAY 15 1945 (Date received local registrar) (b) J. F. Breeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12 year 1945 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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

23. Signature (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed D M David

Licensed Embalmer No. 3741

P. O. Address 1926 Allen ave

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, fact should be so stated above.