S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 1 1945

State File No. 26621

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3563

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Vinyard Park Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs (Specify whether

In this community 20 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. 2816 - East - 6 St. (If rural, give location) 8

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME John F. Swarens

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male C

5. Color or race White

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

6. (b) Name of husband or wife Sottie Swarens

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

7. Birth date of deceased July - 3 (Month) 1865 (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	1	20	hr. min.

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

10. Usual occupation Medical Doctor

11. Industry or business

FATHER
12. Name Wm. L. Swarens
13. Birthplace (City, town, or county) No Record (State or foreign country)

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

16. (a) Informant Mrs. Maude Lamb

(b) Address 2816 - E - 6 St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 8-25-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 23 year 1945 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from Jan 1, 1945, to Aug 23, 1945; that I last saw him alive on Aug 23, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Occlusion of Coronary Artery	5 min.
Due to: Arteriosclerosis	1 yr.
Due to:	
Other conditions: 1st. Occlusion 1-1-45 (Include pregnancy within 3 months of death)	

Major findings:
Of operations 94a
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 0

23. Signature J. G. Sheldon (M. D. or other)

Address 62 [illegible] Date signed 8-24-45

(Licensed Embalmer's Statement on Reverse Side)

A. C. 140

Dr Sheldon
Com Bldg
Vi 4175 - 12 to 3 Pm
Hosp - Oct 2 1982

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 Cortland Minor

Licensed Embalmer No. 3414

P. O. Address 918 Brooklyn

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.