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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **7027**
 Registrar's No. **2236**

FILED MAR 14 1947
318

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Lukes Hospital 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Indiana** (b) County..... **Vigo** **999**
 (c) City or town..... **Terre Haute** **12**
 (If outside city or town limits, write "RURAL")
 (d) Street No..... **2118 So. 8th St.** **NR0**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No) **2**
 If yes, name country.....

3. (a) PRINT FULL NAME **Fairy Swartz**

3. (b) If veteran, name war..... **No** 3. (c) Social Security No..... **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife..... **Roy B. Swartz** 6. (c) Age of husband or wife if alive **62** years
 7. Birth date of deceased **July 29 1884**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 **6** **24** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **Jeff Buck 0**

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

14. Maiden name **Cedona Grey**

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

16. (a) Informant **Cedona Swartz**

(b) Address **2118 So. 8th St., Terre Haute Ind.**

17. (a) **Removal** (b) Date thereof **3-4-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Terre Haute, Ind.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **Mar 4 1947** (b) **J. F. Bredenk**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **3rd** year **1947** hour **5** minute **10 A.M.**
 21. I hereby certify that I attended the deceased from **Jan 1 1946** to **his death 3/3 1947**
 that I last saw her alive on **March 3 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart Failure** Duration **1 year**
 Due to **Rheumatic Heart disease**
valvular stenosis
 Due to **Cardiac hypertrophy**
 Other conditions.....
 (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations.....
 Of autopsy **confirmed clinical diagnosis**
 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 **Julius J. Jussaw** (M. D. or other) **MD**
 Address **3726 Wash St. An. Ind.** Date signed **3/4/47**

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..... *Elms R. Caswell*

Licensed Embalmer No..... *4077*

P. O. Address.....

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.