

FILED MAR 31 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11594
State File No. _____
Registrar's No. **2988**

Registration District No. _____ Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
126 E. Poepping St.
(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)

3. (a) PRINT FULL NAME **Katherine (Kate) Swanson**

3. (b) If veteran, name war **no** 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Edward** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **February 2 1882**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	1	17	hr. _____ min. _____

9. Birthplace: **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Henry P. Potthoff**

13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Lena Fischer**

15. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward Swanson**

(b) Address **126 E. Poepping St.**

17. (a) **Burial** (b) Date thereof **March 22-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
Park Lawn Cemetery

18. (a) Signature of funeral director **C. Hoffmeister U. & L. Co.**

(b) Address **7814 S. Broadway**

19. (a) **MAR 20 1947** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **0-00**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **126 E. Poepping St.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **19**
year **1947** hour **10** minute **40 A.**

21. I hereby certify that I attended the deceased from **1939**
to **death**, 19____, to _____, 19____,
that I last saw her alive on **Mar. 18**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic heart disease**

Due to _____
Due to _____

Other conditions **Arricular fibrillation**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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)
Means of injury _____

23. Signature **Debra J. Burke** (M. D. or other) **MD**
Address **5203 Chippewa** Date signed **3-20-47**

Duration **47 yrs.**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

5203 Chapin

726017

Thursday 10 PM

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

Louis C. Hoffmeister

Licensed Embalmer No.

3871

P. O. Address

7814 S. Beach

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.