

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32242

State File No. 7811

318

1003

Registrar's No. 7811

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wellston</u>		96		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospt</u>				STREET ADDRESS (If rural, give location) <u>6751 Wynhill Drive</u>				
3. NAME OF DECEASED (Type or Print) <u>FRANK</u>		b. (Middle) <u>A.</u>		Swahlstedt		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 7 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct 9 1870</u>		
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Machinist</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Frank A. Swahlstedt</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Larson</u>			14. NAME OF HUSBAND OR WIFE <u>Emma Swahlstedt, Dec.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>491-14-9969</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank M. Swahlstedt, 6751 Wynhill</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Urterial obstruction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of prostate</u> DUE TO (c) <u>Metastatic Carcinoma of Colon</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>ARTERIO-SCLEROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 yr</u> <u>6 mos.</u> <u>2 yrs.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>51</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>177X</u>				
22. I hereby certify that I attended the deceased from <u>Jan 1947</u> , to <u>Sept 7, 1949</u> , that I last saw the deceased alive on <u>Sept 7, 1949</u> , and that death occurred at <u>9:20 a. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Wm. A. Clark M.D.</u>				23b. ADDRESS <u>8924 St. Charles St. St. Louis, Mo.</u>		23c. DATE SIGNED <u>9/7/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 10 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemt</u>		24d. LOCATION (City, town, or county) / (State) <u>St. Louis County Mo.</u>		
DATE REC'D BY LOCAL REG. <u>SEP 9 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos. W. Clark 1125 Hodiamont Ave</u>				

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

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Robert M Murray

Signed.....

Student Embalmer

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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, fact should be so stated above.