No. 300
10-46

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

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15055

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2990

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS Mo
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2049 - ALLEN

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS 2239
d. STREET ADDRESS (If rural, give location): 2049 ALLEN

3. NAME OF DECEASED (Type or Print)
a. (First): ALOISIE
b. (Middle): —
c. (Last): SWEHLA

4. DATE OF DEATH (Month) (Day) (Year): APRIL 30 1950

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: JUNE 8 1885
9. AGE (In years last birthday): 64 — If under 1 year: Months 10, Days 22 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): MISSOURI
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: MARTIN EKL
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND ~~OR WIFE~~: JOHN J. SWEHLA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: JOHN J. SWEHLA — ADDRESS: 2049 ALLEN

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: about

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): of Left Breast — 5 yrs.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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): 170X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10 1945, *to* April 30, 1950, *that I last saw the deceased alive on* April 30, 1950, *and that death occurred at* 9:55 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): D.O.
23b. ADDRESS: 3606 Traine
23c. DATE SIGNED: 5/2/50

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: MAY 3 1950
24c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM
24d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

DATE REC'D BY LOCAL REG. MAY 2 1950
REGISTRAR'S SIGNATURE: J. B. Lacaster
25. FUNERAL DIRECTOR'S SIGNATURE: Thomas Kutis — ADDRESS: 2906 Gravois

(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Leo J. Budde

Signed.....
Student Embalmer

Licensed Embalmer No. 3989

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.