

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30476

State File No. \_\_\_\_\_  
Registrar's No. 7584

FILED AUG 31 1953

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 7024 Dale Ave.		e. STREET ADDRESS (If rural, give location) 4 7024 Dale Ave.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Lyal		(Month) (Day) (Year) Aug. 1 1953	
b. (Middle) V.			
c. (Last) Swinhart			
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 8, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Fireman		10b. KIND OF BUSINESS OR INDUSTRY City of St. Louis	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri
13a. FATHER'S NAME Lyal Swinhart		13b. MOTHER'S MAIDEN NAME Ann Gannon	14. NAME OF HUSBAND OR WIFE Mary Swinhart
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Swinhart - 7024 Dale Ave.
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) <i>Hemiplegia (Left)</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Cardiovascular Heart Disease 1950</i> DUE TO (c) <i>General Cardiovascular Disease ?</i> II. OTHER SIGNIFICANT CONDITIONS <i>Senile Dementia ?</i>	
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) <i>422.1</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 1950</i> to <i>Aug 1953</i> , that I last saw the deceased alive on <i>Aug 12</i> , 1953, and that death occurred at <i>4 P. m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>August G. Nicholson - M.D.</i>		23b. ADDRESS <i>4660 Maryland</i>	23c. DATE SIGNED <i>8/2/53</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE <i>Aug. 4, 1953</i>	24c. NAME OF CEMETERY OR CREMATORY <i>New St. Marcus Cemetery</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis Missouri</i>
DATE REC'D BY LOCAL REG. <i>AUG 4 1953</i>	REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>W. H. Stacker - Felder - 3634 Gravois Ave.</i>	

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 2678  
P. O. Address.....  
Dr. Reid

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**