Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003559

STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 218 Primary Registration District No. 1003 Registrar's No. 61

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Chronic Hosp. — Length of stay in 1b 11 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 2129 4553 Delmar Blvd. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Louis Middle C. Last Swinnen

4. DATE OF DEATH Month 1-3-59 Day Year

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3/28/1873

9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months 9 Days 4 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Mo.

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME JOSEPH SWINNEN

13b. MOTHER'S MAIDEN NAME -- CATHERINE ILLIG

14. NAME OF HUSBAND OR WIFE OTALIE SWINNEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. NO

17. INFORMANT CATHERINE WHETZEL Address OFALLON MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	old + 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Coronary Thrombosis	1 mo.
DUE TO (c)	Arteriosclerotic Heart Disease	1 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12-23-58, to 1-3-59 and last saw her/him alive on 1-3-59
Death occurred at 1:32 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.

22b. ADDRESS 5800 Arsenal

22c. DATE SIGNED 1/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE JAN 5 1959

23c. NAME OF CEMETERY OR CREMATORY OFALLON

23d. LOCATION (City, town, or county) (State) OFALLON Mo

24. FUNERAL DIRECTOR Bill Campbell ADDRESS 5165 Delmar

25. DATE RECD. BY LOCAL REG. JAN 5 '59

26. REGISTRAR'S SIGNATURE J Earl Smith MD MKB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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. .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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