

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. MAY 13 1960

318

1003

=60-017385

STATE FILE NUMBER

4689

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>1 DAY</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>INCARNATE WORD HOSPITAL</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6644 MARQUETTE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>AUGUSTA SWANSON</b>				4. DATE OF DEATH Month Day Year <b>MAY 2 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/8/1883</b>	
9. AGE (last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.		9. AGE (last birthday) <b>77</b>		IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT EMPLOYED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NTL</b>		11. BIRTHPLACE (City and state or country) <b>CHICAGO, ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>				13a. FATHER'S NAME <b>JOHN B. BORLING</b>			
13b. MOTHER'S MAIDEN NAME <b>EMMA SKOG</b>				14. NAME OF HUSBAND OR WIFE <b>GEORGE W. SWANSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. DON LARSON, 6644 MARQUETTE, ST. LOUIS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DIS 1 yr.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>WITH CONGESTIVE FAILURE 1 Mo</b> DUE TO (c) <b>ANEMIA, Hypoplastic 6 Mo</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>420.0</b>			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>1950</b> , to <b>5/2/60</b> , and last saw <sup>her</sup> <sub>him</sub> alive on <b>5/2/60</b> Death occurred at <b>8:15 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>D. Michael M.D.</b>				22b. ADDRESS <b>812 Olive</b>		22c. DATE SIGNED <b>5/3/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>5/3/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKWOOD CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CHICAGO (COOK CO.) ILLINOIS</b>	
24. FUNERAL DIRECTOR ADDRESS <b>HOFFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET, ST. LOUIS, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 3 1960</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*2092*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Linus C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. Br

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.