

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021603

FILED VS MAY 1 9 1960

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STATE FILE NUMBER

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 Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | | Length of stay in 1b 3 Yrs | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1515 Rear Franklin | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Abe Middle I Last Swink | | | | 4. DATE OF DEATH Month 5 Day 5 Year 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH I-2-1900 | 9. AGE (last birthday) 60 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | | 10b. KIND OF BUSINESS OR INDUSTRY DOMESTICTS | | 11. BIRTHPLACE (City and state or country) STGENESSEE COUNTY MO. | | 12. CITIZEN OF WHAT COUNTRY U.S.A |
| 13a. FATHER'S NAME EDWARD B. BAILEY SWINK | | | 13b. MOTHER'S MAIDEN NAME ELLA ROBINSON | | | 14. NAME OF HUSBAND OR WIFE ----- | |
| 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. ? | 17. INFORMANT Jurley Schubert | | Address 4236, A BASTON AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach, Generalized Carcinoma of Abdomen DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 151x | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Undet. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) | | | |
| 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 4-7-60 to 5-5-60 and last saw him alive on 5-5-60 Death occurred at 6:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Sydney A. Mason, M. D. | | | | 22b. ADDRESS 2601 N. Whittier St. | | 22c. DATE SIGNED 5-6-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE 5-10-1960 | 23c. NAME OF CEMETERY OR CREMATORY OAKDALE CEMETERY | | 23d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI | | |
| 24. FUNERAL DIRECTOR John D. Houston | | | ADDRESS 2812, THOMAS ST. | 25. DATE RECD. BY LOCAL REG. MAY 10 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____

Licensed Embalmer No. 444

P. O. Address 2812 Wh

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.