

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-046914

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11217

STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased livgd. If institution: Residence before admission) a. STATE <i>Illinois</i> COUNTY <i>St. Clair</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>	Length of stay in 1b <i>1 day</i>	c. CITY OR TOWN <i>East St. Louis</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital # 1</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>8322 State Street</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>John Edward Swindle</i>			4. DATE OF DEATH Month Day Year <i>November 30, 1961</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>8/29/22</i>	9. AGE (last birthday) <i>39</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sign Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>American Jewelite Co</i>		11. BIRTHPLACE (City and state or country) <i>Carbondale Alabama</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>David Swindle</i>		13b. MOTHER'S MAIDEN NAME <i>Maggie Reed</i>		14. NAME OF HUSBAND OR WIFE <i>Sue Swindle</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>yes World War 2</i>		16. SOCIAL SECURITY NO. <i>496-20-9720</i>		17. INFORMANT Address <i>Mrs Sue Swindle, East St. Louis Illinois</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Subdural + Exdural Hemorrhage of right side of head suffered in fall from scaffold to ground below, while working at 3001 Gravois ave., about 5:45 P.M. on Nov. 29, 1961</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONTRIBUTING TO DEATH (If any, state the disease condition given in PART I (a)) <i>902.6-09</i>		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>See above</i>
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20c. TIME OF INJURY Hour <i>3:45</i> a.m. p.m. Month, Day, Year <i>11-28-61</i>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <i>Building</i>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Building</i>	20f. CITY, TOWN, OR LOCATION <i>St Louis, Mo</i>	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ <i>4-0-A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>Joseph M. Swindle</i>	22b. ADDRESS <i>1300 Clair</i>	22c. DATE SIGNED <i>12-2-61</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>12/4/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Normandy Missouri</i>
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24. FUNERAL DIRECTOR <i>Shepard Funeral Home, 1167 Hamilton Ave</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 2 1961</i>	26. REGISTRAR'S SIGNATURE <i>Loed Smith M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

