MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

26450

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City St. Louis, (No. 1917a Victor st., St. ..... Ward)

File No. .....

Registered No. 7709

2. FULL NAME Robert E. Swacker.

(a) Residence. No. ..... St., 23 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Julia Swacker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1870-11-11

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day; ..... hrs. or ..... min.
	58	8	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Foster Falls,
(STATE OR COUNTRY) Va.

PARENTS

10. NAME OF FATHER Benj. F. Swacker.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Va.

12. MAIDEN NAME OF MOTHER Mary Morris.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Va.

14. INFORMANT Nelly Swacker
(Address) 1917a Victor st.

15. FILED Oct 25 1929 Mae C Sander REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 23rd. 1929

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to July 23rd, 1929, that I last saw him alive on ....., 19....., and that death occurred, on the date stated above, at 7 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

(duration) 1 yrs. 1 mos. — ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Physical Diag.

(Signed) Dal Morris Hansel M. D.

7/24/29. (Address) 2029a S. Broadway

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hopewell, Mo.

DATE OF BURIAL 7/26/29

20. UNDERTAKER Robert Funeral Home

ADDRESS 4468 Washington av

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

R. J. Ambrosetti
427 [illegible]