Boyer

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

Do not use this space.
15457
15188

1. PLACE OF DEATH

County..... Registration District No. 7911 1003

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

City St Louis Mo (No. 1917 Victor St. Ward)

File No.....
Registered No. 4394

2. FULL NAME Benjamine Franklin Swacker

(a) Residence. No. 1917 Victor St. St. 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Mary M Swacker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16 - 1846

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
81	10	6	

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) Virginia
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Jacob Swacker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Robert E Schwacker
(Address) 1917 Victor St.

15. FILED APR 23 1925 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 22 1928

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1928, to April 22, 1928, that I last saw h. alive on April 21, 1928, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(a) Cardiac Decompensation
(b) 92 [illegible]
(c) 93 [illegible]
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Chronic Endocarditis
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Don't Know
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

(Signed) Dr Lewis Francis M.D.
, 19 (Address) 5835 Bowen

*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	DATE OF BURIAL
Hopewell Mo	4-24-28
20. UNDERTAKER J. T. Boyer	ADDRESS Lindwood Mo

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.

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