

Every item of information 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.

26

1 PLACE OF DEATH

County Knock  
 Township Shelton  
 or  
 Village  
 or  
 City No. \_\_\_\_\_ St., \_\_\_\_\_ Ward \_\_\_\_\_

7029  
5602

SOUTH DAKOTA  
 STA. E BOARD OF HEALTH  
 Division of Vital Statistics

27637

CERTIFICATE OF DEATH

Reg. District No. 1029-5602 No. in Registration Book 85  
 (Above numbers to be filled in only by local registrar or his deputy.)

2 FULL NAME Mary Swann  
 (2) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (WRITE the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH (month, day, and year) \_\_\_\_\_

7 AGE Years Months Days If LESS than 1 day, ... hrs. or ... min. 18 2 8

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH SEPT (Month) 12 (Day) 1927 (Year)

11 I HEREBY CERTIFY, That I attended deceased from 9:30 AM Sept 11, 1927 to 9:30 AM Sept 12, 1927 that I last saw her alive on 9 PM Sept 11, 1927 and that death occurred on the date stated above, at \_\_\_\_\_ 4 A. m. \_\_\_\_\_ 11 A

8 OCCUPATION OF DECEASED

(a) Trade, Profession, or particular kind of work Housekeeper

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

(c) Name of employer \_\_\_\_\_

The CAUSE OF DEATH\* was as follows: 111 B  
Acute edema of lungs  
Influenza Pneumonia

CONTRIBUTORY (Secondary) Influenza

9 BIRTHPLACE (city or town) Edina, Mo.  
 (State or country) Armo, Mo.

18 Where was disease contracted Armo, Mo.

10 NAME OF FATHER G H Swann

19 If not at place of death? \_\_\_\_\_  
 Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_  
 Was there an autopsy? \_\_\_\_\_  
 What was the confirmed diagnosis? Cholera

11 BIRTHPLACE OF FATHER (city or town) Edina  
 (State or country) Armo, Mo.

20 (Signed) M. D.  
9-12-27 (Address) Edina Mo

12 MAIDEN NAME OF MOTHER Myrtle Sell

\*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. (See reverse side for additional space.)

13 BIRTHPLACE OF MOTHER (city or town) Marionville  
 (State or country) Mo.

14 Informant G H Swann  
 (Address) \_\_\_\_\_

19 Place of Burial, Cremation, or Removal Novelty Mo. Date of Burial 9-13-27

15 Filed Oct 1 1927 Matthie Horvontor  
 (Signature of Registrar)

20 UNDERTAKER L W Hudson ADDRESS Edina Mo

Justice of Peace 19 Burial permit issued

[The main body of the page is mostly blank with scattered noise and artifacts.]

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

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Henry  
 Township Shelton  
 City Shelton

Registration District No. 1829  
 Primary Registration District No. 5602

File No. 83-  
 Registered No. \_\_\_\_\_  
 (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

**2. FULL NAME**

Mary Swan

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

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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-4-1909

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
18 8 8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14. INFORMANT \_\_\_\_\_  
 (Address)

15. FILED Oct 1 1927 Mattie Choverton  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 1927

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH, \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY, \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS, \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

19

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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.

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