

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

Do not use this space.

20308

JUL 4 1930

1. PLACE OF DEATH

County Pike
Township Adrian
City Adrian

Registration District No. 689
Primary Registration District No. 30313

File No. _____
Registered No. _____
St. _____ Ward)

2. FULL NAME

(a) Residence. No. _____ St., _____ Ward.

(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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

10/14-83

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
46	8	7	

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)

Pike Co Mo

PARENTS

10. NAME OF FATHER

James M Swinney

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

Pike Co Mo

12. MAIDEN NAME OF MOTHER

Mable Muth

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

Pike Co Mo

14. INFORMANT (Address)

Mrs Mable Swinney
Adrian Mo

15. FILED

6/7 1930 J. O. Haeberle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

July 21 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer Stomach

4 1/2 yrs (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY)

4 1/2 yrs (duration) 0 yrs. 0 mos. 0 ds.

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) D. M. Pearson, M.D.

6/24 1930 (Address) Louisiana Mo

*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

Clarksville, Missouri 6/23 1930

20. UNDERTAKER

ADDRESS

W. B. Bradley Clarksville 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.

