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.

30

DEC'D MAR 15 1939

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

6355
Do not use this space.

1. PLACE OF DEATH
(a) County Dallas 2 Registration District No. 247
(b) Township Wilson 1 Primary Registration District No. 5343 Registered No. 4
(c) City Long Lane (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 263 Alma Swingart
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
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) July 14-1938
7. AGE YEARS MONTHS 7 DAYS 11 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co. Mo.

FATHER
13. NAME Odis Swingart
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co. Mo.

MOTHER
15. MAIDEN NAME Alma Hazel Harris ~~Swingart~~
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co. Mo.

17. INFORMANT (ADDRESS) Odis Swingart Long Lane Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Four Mile Cem. DATE 2-26 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones Buffalo Mo.
20. FILED 2-10-1939 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-25 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 3:30 a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	?

Other contributory causes of importance: 108

Name of operation ✓ Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ✓ Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ✓
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ✓
If so, specify .....
(Signed) L. B. Jones M. D.
(Address) Coroner of Dallas Co Buffalo Mo

224

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 7-39-48
Date Filed 3-13-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.