AUG 7 1939

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

24686
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson | Registration District No. 399
(b) Township Raw | Primary Registration District No. 100 | Registered No. 2899
(c) City or K.C. Mo (d) Street No. Wesley Hospital 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 Miss Lillian Swenson
(a) Residence, No. 209 So Monroe 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) Aug 21-1880

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	10	26	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home
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) Osage Kansas

FATHER
13. NAME Casper Swenson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

MOTHER
15. MAIDEN NAME Emma Johnson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

17. INFORMANT Mrs Anna Ackerson
(ADDRESS) 209 So Monroe

18. BURIAL, CREMATION, OR REMOVAL
PLACE Osage Kan DATE 7-18-39

19. FUNERAL DIRECTOR (NAME) J. W. Wagner
(ADDRESS) Kansas city Mo

20. FILED July 17, 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 17, 1939

22. I HEREBY CERTIFY That I attended deceased from 7/13, 1939, to 7/16, 1939
I last saw h. alive on 7/16, 1939 Death is said to have occurred on the date stated above, at 1:30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Obstruction of Bowels with perforation Due to Pathesion	7/13
Other contributory causes of importance:	

Name of operation Op. for Ob. of Bowel Date of 7/14/39
What test confirmed diagnosis? Was there an autopsy? No

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) R. H. Williams, M. D.
(Address) 5-4 Dd St John Ad
K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

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.