

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

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.

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

39435  
Do not use this space.

REC'D DEC 15 1939

1. PLACE OF DEATH

(a) County Crawford Registration District No. 1113  
(b) Township Osage Primary Registration District No. 5317  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(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.

Registered No. \_\_\_\_\_

2. PRINT FULL NAME Minnie Swyers

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10 1862

7. AGE YEARS 77 MONTHS 6 DAYS 20 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. None  
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) Tennessee

FATHER 13. NAME Stulse

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

MOTHER 15. MAIDEN NAME \_\_\_\_\_

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

17. INFORMANT Lena Setzer (ADDRESS) 9111 1/2 Dillard Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Dillard Cem DATE 11-30-39 19. \_\_\_\_\_

19. FUNERAL DIRECTOR (NAME) L. J. Jonas (ADDRESS) Steellville, Mo.

20. FILED 11-30 1939 E. E. Feltz Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-29-39 1939

22. I HEREBY CERTIFY, That I attended deceased from 11/10, 1939, to 11/29, 1939

I last saw her alive on 11/29, 1939. Death is said to have occurred on the date stated above, at 1245Pm. The principal cause of death and related causes of importance were as follows:

Influenza  
(without pneumonia)  
with pleurisy

Date of onset

Other contributory causes of importance: 11/29

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) J. G. Greener, M. D.  
Widener Mo (Address)

**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.

**RECEIVED**

District Health Officer No. 5,

Signed.....

District File Number 1239-482

Licensed Embalmer No.....

Date Filed 12-13-39

P. O. Address.....

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

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39421-  
Do not use this space.

1. PLACE OF DEATH

(a) County Crawford Registration District No. 1113  
(b) Township Osage Primary Registration District No. 2317 Registered No. ....  
(c) City ..... (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 Minnie Surgers

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid

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

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

7. AGE YEARS 77 MONTHS 6 DAYS 20 If LESS than 1 day, .... hrs. or .... min.

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

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

15. MAIDEN NAME Margaret Carr

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 11-30 1939 E E Felt Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-29 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to ....., 19.....

I last saw h..... alive ..... 19..... Death is said to have occurred on the ..... stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

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) J. C. Monches M. D.  
J. Vieman (Address) wid

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.

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

SUPPLEMENTARY

