

FILED MAR 7 - 1940

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

7084

Do not use this space.

1. PLACE OF DEATH

(a) County Johnson Registration District No. 431
 (b) Township Warrensburg Primary Registration District No. 2023
 (c) City Warrensburg (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred yrs. 9 mos. da. _____ (f) How long in U. S., if of foreign birth? yrs. mos. da. _____

Registered No. 27

2. PRINT FULL NAME

(a) Residence, No. 2609 John Charles Swisher 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Philipine Swisher
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 7, 1857
 7. AGE YEARS 82 MONTHS 9 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 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) Virginia13. NAME Samuel Swisher14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson, Mo.15. MAIDEN NAME Fauber16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson, Mo.17. INFORMANT Wm Swisher (ADDRESS) Sutton, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Windsor, Mo. DATE Feb 18, 194019. FUNERAL DIRECTOR (NAME) R.A. Brauninger (ADDRESS) Sutton, Mo.20. FILED Feb 18, 1940 Eva Gentry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 17th, 194022. I HEREBY CERTIFY, That I attended deceased from 1-6, 1940 to 2-17, 1940I last saw him alive on 2-16, 1940 Death is said to have occurred on the date stated above, at 9:22 A. m.

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

Myocardial degeneration

Date of onset _____

Other contributory causes of importance:

Fracture of femur 1-6-40

Name of operation _____ Date of _____

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. Lee Cooper M. D.391 (Address) Warrensburg, Mo.

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.

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RECEIVED
District Health Officer No. 8
District File Number
Date Filed 3/6/40

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

Signed W. A. Brummer
Licensed Embalmer No. 3377
P. O. Address Luton, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7084

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 431

Primary Registration District No. 3023

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County... Johnson

(b) City or town... Warrensburg
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME John Charles Swisher

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

82 9 10 _____ h. _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 17
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Myo Cardial degeneration

Due to _____

Due to _____

Other conditions fractured femur

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 1-6-40

(c) Where did injury occur? Warrensburg Johnson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In His Bedroom

While at work? no (Specify type of place) (e) Means of injury tripped on floor

23. Signature R. Lee Cooper M. D. _____

Address Warrensburg Mo Date signed 4/9/40

SUPPLEMENTARY

S-7084