

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH *St. Louis* 10864 State File No. _____

Registration District No. 287 Primary Registration District No. 5405 Registrar's No. 4

1. PLACE OF DEATH: (a) County Dunklin (b) City or town Senath mo (c) Name of hospital or institution: _____ (d) Length of stay: In hospital or institution 2 (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED: (a) State Missouri (b) County Dunklin (c) City or town Near Senath (d) Street No. 0 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Clarence Guy Swinell (b) If veteran, NO name war _____ (c) Social Security No. NONE

MEDICAL CERTIFICATION 20. DATE OF DEATH: Month Jan day 27 year 1949 hour 7 minute 20 M. 21. I hereby certify that I attended the deceased from Jan 21-49 to Jan 27-49 that I last saw him alive on Jan 27-49 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years 7. Birth date of deceased: Sept 11 1878 (Month) (Day) (Year)

Immediate cause of death: Pneumococcus pneumoniae Duration 10 days Due to _____ Due to _____

8. AGE: Years 61 Months 4 Days 16 If less than one day hr. _____ min. 9. Birthplace Kentucky (City, town, or county) (State or foreign country) 10. Usual occupation farmer

Other conditions (Include pregnancy within 3 months of death) _____ Major findings: Of operations _____ Of autopsy _____

MOTHER FATHER 11. Industry or business _____ 12. Name Green Swinell 13. Birthplace unknown (City, town, or county) (State or foreign country) 14. Maiden name Margaret Summers 15. Birthplace unknown (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) _____ (b) Date of occurrence _____ (c) Where did injury occur? _____ (City or town) (County) (State) (d) Did injury occur in or about home, on farm, in industrial place, in public place? 2 In O (Specify type of place) _____ (e) Means of injury _____

16. (a) Informant's own signature Mrs. C. H. Swinell (b) Address Senath mo 17. (a) Funeral (b) Date thereof 1-29-49 (Burial, cremation, or removal) (Month) (Day) (Year) (c) Place: burial or cremation Cape 18. (a) Signature of funeral director George J. Gilmore (b) Address Senath, Mo (c) 18-40 (Date received local registrar) (Registrar's signature)

23. Signature George J. Gilmore (M.D. or other) _____ Address Senath mo Date signed 1-25-49

109

RECEIVED

District Health Officer No. 2,

District File Number 440-87

Date Filed 4/2/40

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.....

H. P. Gook, Registered Apprentice No.....
working under my personal supervision.

Signed H. P. Gook
Licensed Embalmer No. 4106

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10864

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 287

Primary Registration District No. 3405

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town Lay
(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 _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Clarence Guy Swindle

(b) If veteran, _____ (c) Social Security No. _____

4. Sex m 5. Color or race w

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

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

61 4 16 _____ hr. _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 Jan day 27 year 1940 hour _____ minute _____ M.

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

Immediate cause of death Pneumococcus Pneumonia

Jan 17 1940

Due to _____

Due to Latent Pneumonia

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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

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

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

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

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature Geo J. Kilgore (M. D. or other) _____

Address Kennett Mo _____

Duration 10 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-10864
1940