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13-40
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X23159

REC'D APR 11 1941
124

Registration District No. 124

Primary Registration District No. 3008

Registrar's No. 84

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 mo. 5 da.
(Specify whether years, months or days)

In this community 8 mo. 5 da.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ellen Swearingen

3. (b) If veteran, name war _____

3. (c) Social Security No. DK

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased March 28, 1892
(Month) (Day) (Year)

8. AGE: Years 48 Months 11 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeping

11. Industry or business _____

MOTHER FATHER { 12. Name James A. Swearingen

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

14. Maiden name Emma B. Wayland

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

16. (a) Informant Hospital records

(b) Address State Hospital No. 1

17. (a) _____ (b) Date thereof 3-23-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethlehem mo.

18. (a) Signature of funeral director Patterson

(b) Address Calumet mo

19. (a) Mar. 21, 1941 (b) R. N. Crewt.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 14

(a) State Missouri (b) County Boone 1

(c) City or town Harrisburg 2
(If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 21 day March
year 1941 hour 8 minute 25 A.M.

21. I hereby certify that I attended the deceased from Jan 1st, 1941, to March 21, 1941; that I last saw her alive on March 20, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Sepsis

Due to Streptococcus infection of Joints and Pharynx since

Due to _____

Duration 24 hrs

2-24-41

Other conditions manic depression psychosis
(Include pregnancy within 3 months of death)

onset April 1921

Major findings: Of operations _____

Of autopsy _____

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) _____

(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)

(c) Means of injury _____

23. Signature P. J. Tate (M. D. or other) MD

Address State Hosp. #1 of Fulton Mo. Date signed 3-21-41

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

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

M. W. McRish

Licensed Embalmer No. *2893*

P. O. Address *Columbia 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, fact should be so stated above.