

Registration District No. **384**

Primary Registration District No. **4227**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **HOWELL**
 (b) City or town **WEST PLAINS**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
336 WALNUT ST.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **No.**
 In this community **22 YEARS** / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **HOWELL** **046**
 (c) City or town **WEST PLAINS** **1**
(If outside city or town limits, write "RURAL")
 (d) Street No. **336 WALNUT**
(If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **22**
 year **1941** hour **12** minute **30 P.M.**
 21. I hereby certify that I attended the deceased from **July 19²⁷** to **June 22** 19**41**;
 that I last saw her alive on **June 21** 19**41**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary hemorrhage
Hemiplegia
 Due to **Arteriosclerosis**
 Due to **93d**
 Other conditions **Senility**
(Include pregnancy within 3 months of death)
Chronic myocarditis
 Major findings:
 Of operations _____
 Of autopsy _____
 Duration _____
 PHYSICIAN _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **ROSA MINERVA SWAN**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **CHARLES T. SWAN** 6. (c) Age of husband or wife if alive **90** years

7. Birth date of deceased **AUGUST 3, 1855**
(Month) (Day) (Year)

8. AGE: Years **85** Months **10** Days **18** If less than one day _____ hr. _____ min.

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

10. Usual occupation **None**

11. Industry or business _____

12. Name **JOE CALL**

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

14. Maiden name **MARGARETTE MCCOY**

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

16. (a) Informant **MRS. LELA LEBLOND**

(b) Address **KANSAS CITY, MO.**

17. (a) **BURIAL** (b) Date thereof **JUN 24, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WEST PLAINS, MO.**

18. (a) Signature of funeral director **Haltzsch**

(b) Address **WEST PLAINS, MO.**

19. (a) **6-24-41** (b) **Vida W. Simons**
(Date received local registrar) (Registrar's signature)

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 **E. L. Barber** (M. D. or other) **MD**
 Address **West Plains, Mo.** Date signed **6-30-41**

344 (Licensed Embalmer's Statement on Reverse Side)

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

X26390

RECEIVED

District Health Officer No. 5,

District File Number

7411784

Date Filed _____

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 _____

Hal Thornburgh

Licensed Embalmer No. _____

3408

P. O. Address _____

West Plains, 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.