

No. 2
1-4-41
17-39
X28390
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DEC 22 1941

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **K. C. Genral Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **Receiving Word**
Unknown (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **Helping Hand**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Emil Ludwigg Swanson**

3. (b) If veteran. _____ name war _____
3. (c) Social Security No. **513-03-4819**

4. Sex **Male** 5. Color or race **White**
6. (a) Single/widowed, married, divorced **Married**
6. (b) Name of husband or wife **MRS Mary Swanson**
6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **SEPT. 8 1878**
(Month) (Day) (Year)

8. AGE: Years **63** Months **2** Days **10**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farm Hand**

11. Industry or business _____

MOTHER FATHER { 12. Name **SWAN SWANSON**
13. Birthplace **Sweden** 4
(City, town, or county) (State or foreign country)
14. Maiden name **MINA NELSON**
15. Birthplace **Sweden** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. Larson**
(b) Address **4115 Michigan**

17. (a) **Burial** (b) Date thereof **NOV. 22 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenbush Cemetery**

18. (a) Signature of funeral director **PASSANTINO BRO'S.**

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

19. (a) **11-21-41** (b) **M. M. Grow**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **18**
year **1941** hour **2** minute **50 p.M.**

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I last saw him/her on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

Heart Failure
Due to **Chronic Pneumonia**
Due to **Chronic Bronchitis**
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____
114 e'
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature **R. M. Grow** (M. D. or other) _____
Address **KC Mo** Date signed _____

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

Mc

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..... **PARK G. ROWE**

Licensed Embalmer No..... **2347**

P. O. Address..... **KANSAS CITY MO.**

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.
Registrar's No. 4321

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town.....
(c) Name of hospital or institution:
General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME Emil L. Swanson

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, Married

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 min.
63

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) 2/30/42 (b) M. M. Brown
(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

20. DATE OF DEATH Month Nov day 18 year 1941 hour..... minute..... M.

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

Immediate cause of death Chronic Bronchitis

Due to Chronic Bronchitis

Due to Chronic Bronchitis

Other conditions (including pregnancy within 6 months of death)

1149
The heart failure was due to Chronic Bronchitis
Major findings: The increased load on the left side of the heart because of
Of operation..... Underline the cause to which death should be charged statistically.
Of autopsy.....

22. If death was due to external causes, affirm the following:
(a) Accident, suicide, or homicide (specify).....

(b) Place of occurrence.....

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

(d) Did injury occur on or about home, on farm, in industrial place, in public place?
No other cause of death

While at work?..... (Specify type of work) (e) Manner of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

S-37526