

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

10806
Do not use this space.

FILED APR 12 1943

1. PLACE OF DEATH

(a) County Macou Registration District No. 203
 (b) Township Lyda Primary Registration District No. 5734
 (c) City Atlanta mo (d) Street No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. William Earl Swind St. Mo
 (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) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Francis Swind
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 2 - 1902
 7. AGE YEARS 40 MONTHS 7 DAYS 16 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labourer
 9. Industry or business in which work was done, as saw mill, bank, etc. Farm work
 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) Macou, Mo

13. NAME William Swind
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Y.
 15. MAIDEN NAME Dollie Burge
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
 17. INFORMANT Francis Swind (ADDRESS) Atlanta mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Berlin DATE 3 - 20 1943
 19. FUNERAL DIRECTOR (NAME) Embolding (ADDRESS) Atlanta mo
 20. FILED Mar 31 1943 Mrs. A. L. Cambon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-18-1943
 22. I HEREBY CERTIFY, That I attended deceased from January 20, 1943, to March 18, 1943
 I last saw him alive on March 18, 1943 Death is said to have occurred on the date stated above at 8 a.m.
 The principal cause of death and related causes of importance were as follows:

Wremia
 Date of onset

Other contributory causes of importance:
 Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 1943
 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) W. E. Lyda, M. D.
 (Address) Atlanta 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.

61
0
0

61
0
0

FORM-1-1
I X14223

RECEIVED

District Health Officer No. 10

District File Number 4-43697

Date Filed APR 10 1943

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,

H M Goodding, or by

Registered Apprentice No., working under my personal supervision.

Signed H M Goodding

Licensed Embalmer No. 1750

P. O. Address Atlanta Ga

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. 10806

Registration District No. 203

Primary Registration District No. 5736

Registrar's No. _____

1. PLACE OF DEATH:

(a) County macon

(b) City or town atlanta
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wm Earl Swind

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 m

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

7. Birth date of deceased aug 2
(Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days 10 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day _____ year 1943 hour _____ minute _____ M.

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

Due to _____

Due to _____

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

Major findings: 132:2

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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-10806