

FILED OCT 7 1943

Registration District No. **128**

Primary Registration District No. **5465**

Registrar's No. **786**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD Rural, N. Campbell**
(c) Name of hospital or institution: **R.F.D. #1 TWP.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 MO.** (Specify whether
In this community **8 MO.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE**
(c) City or town **SPRINGFIELD Rural, N. Campbell**
(If outside city or town limits, write "RURAL") **TWP.**
(d) Street No. **R.F.D. #1** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **no**

3. (a) PRINT FULL NAME **JAMES EMERSON SWAFFORD**

MEDICAL CERTIFICATION

3. (b) If veteran, **NONE** name war. 3. (c) Social Security No. **NONE**

20. DATE OF DEATH: Month **Sept.** day **22**
year **1943** hour **9** minute **30 A.M.**

4. Sex **male** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **MYRTLE SWAFFORD**
6. (c) Age of husband or wife if alive **45** years
7. Birth date of deceased **OCT. 24 1880**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9/13** 19**43** to **9/22/** 19**43**
that I last saw him **alive** on **9/12/** 19**43**
and that death occurred on the date and hour stated above.

8. AGE: Years **62** Months **10** Days **28** If less than one day
hr. min.

Immediate cause of death **Decompensating Heart Lesion Chronic Myocarditis**
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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

10. Usual occupation **Farmer**

11. Industry or business **Farming**

12. Name **Jasper Swafford**

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

14. Maiden name **Fannie Summers**

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

16. (a) Informant **Myrtle Swafford**
(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **SEPT 25-43**
(Month) (Day) (Year)

18. (a) Signature of funeral director **J. W. Klingner**
(b) Address **SPRINGFIELD MO.**

19. (a) **9-23-43** (Date received local registrar) (b) **D. W. H. H. H.** (Registrar's signature)

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) (e) Means of injury
23. Signature **C. E. Fuller** (M. D. or other)
Address **Springfield Mo.** Date signed **9/24/43**

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

39
0
0

MOTHER FATHER

NOV 19 1945

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

Ogle Stone Jr.

Licensed Embalmer No.

4176

P. O. Address

Springfield

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.

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