

FILED FEB 19 1944
Registration District No. 1002

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K. C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community 20 yr (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay
(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 403 Benton (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Wilfred, Swafford

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

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edna 6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased March 12, 1913
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 3 12 hr. min.

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

10. Usual occupation reported

11. Industry or business

12. Name Austin Swafford

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

14. Maiden name Rachael Cameron

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

16. (a) Informant Hospital records K. C. Mo.

(b) Address 24th Cherry

17. (a) Burial (b) Date thereof 1-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Excelsior Springs

18. (a) Signature of funeral director Herbert Hope (Specify type of place)
(b) Address Excelsior Spgs (c) Means of injury

19. Jan 18, 1944 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17
year 1944 hour 9:50 minute 50 P.M.

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

Immediate cause of death Pneumococcal Meningitis

Due to 8/2

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy See Above

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?

23. Signature A. E. Warner (M. D. or other)
Address 25 M. E. Way Date signed 1/18/44

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

MOTHER FATHER

OCT 19 1948

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.....

Gas Moles

Licensed Embalmer No. *3296*

P. O. Address. *Ev Spgs Md*

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.