

FILED NOV 8 1944

Registration District No. _____

Primary Registration District No. **5935**

Registrar's No. **350**

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

1. PLACE OF DEATH:

(a) County **Pettis**
 (b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Sedalia (Twp)**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community **3 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Pettis**
 (c) City or town **Rural Sedalia (Twp)**
(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 **Martha A. Swerngin**

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

4. Sex **F.** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

7. (b) Name of husband or wife **James Swerngin** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **Aug 17 1886**
(Month) (Day) (Year)

8. AGE: Years **33-37** Months **2** Days **7** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business **Home**

12. Name **Jon W. Mc Calister**

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

14. Maiden name **Almeada Thomas**

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

16. (a) Informant **James Swerngin**

(b) Address **Sedalia Mo.**

17. (a) **Burial** (b) Date thereof **Oct 26-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **B.F. Parker** **Sedalia Mo**

(b) Address **La Monte Mo**

19. (a) **19-35-1944** (b) **Miss Anna Berger**
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **24th** = **44**
 year **1944** hour **12** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **9-1-44** to **10-24-44**

that I last saw **her** alive on **Oct 24** 19**44**

and that death occurred on the date and hour stated above.

Immediate cause of death **Endocarditis** Duration _____
Endocarditis -

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **None**

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 **P. Connaday** (M. D. certifier)
 Address **132 1/2 So Ohio** Date signed **10-25-44**

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-2-47

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 B. F. Cannon

Licensed Embalmer No. 1192

P. O. Address Hammond

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.