

FILED JUN 14 1945
Registration District No. **247**

Primary Registration District No. **4360**

Registrar's No. **26**

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Portageville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **40 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Alpha Franklin Swilley**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Samuel Swilley** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **Oct. 13 1877**
(Month) (Day) (Year)

8. AGE: Years **67** Months **6** Days **26** If less than one day hr. min.

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

10. Usual occupation **Retired Mechanic**

11. Industry or business _____

12. Name **A. F. Swilley**

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

14. Maiden name **Julia Taylor**
15. Birthplace **New Madrid Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Samuel Swilley**

(b) Address **Portageville Mo**

17. (a) **Burial** (b) Date thereof **May 11 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Portageville Mo**

18. (a) Signature of funeral director: **D. P. ... Funeral Parlor**

(b) Address **Portageville, Missouri**

19. (a) **5-10-45** (b) **Ellen Dedrick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **New Madrid**
(c) City or town **Portageville Mo**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **9**
year **1945** hour **11** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **May 9 1945** to **May 9 1945**
that I last saw him alive on **May 9 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Coronary Occlusion (Thrombotic)**
Duration **26 hrs**

Due to _____

Due to **Arteriosclerosis** **6 yrs**

Other conditions **none**
(Include pregnancy within 3 months of death)

Major findings: Of operations **none**

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 **L. C. Conrad** (M. D. or other) **M.D.**
Address **Portageville, Mo** Date signed **5-10-45**

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

0679

RECEIVED

District Health Office No. 2

District File Number 645-847

Date Filed 6-12-45

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed

Leonard J. Vargo

Licensed Embalmer No.

4336

P. O. Address

Fortageville, W.

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.