V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36607

Registration District No. 36 Primary Registration District No. 5118 Registrar's No. 7

1. PLACE OF DEATH:

(a) County Boone

(b) City or town McBaine Missouri Twp

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 1 Month

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town McBaine

(If outside city or town limits, write "RURAL")

(d) Street No. Route 1

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME WALTER JAMES SWAFFORD

3. (b) If veteran, name war

3. (c) Social Security No. 486-22-0386

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence Salmon Swafford

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

7. Birth date of deceased 4 - 23 - 1922 (Month) (Day) (Year)

8. AGE: Years 23 Months 5 Days 6 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Railroad Station Attendant

11. Industry or business

FATHER
12. Name William Swafford
13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Hattie Langlay
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Mrs. W.J. Swafford

(b) Address Route 1, McBaine, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia, Mo.

19. (a) 10/5/45 (Date received local registrar) (b) MRS. Wm H. ANGELL (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29 year 1945 hour 6 minute 40 P. M.

21. I hereby certify that I attended the deceased from Sep 29, 1945, to Sep 29, 1945 that I last saw him alive on Sep 29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of Lungs — Duration 2 mo

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations X

Of autopsy

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 X

(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 [signature] (M.D. or other)

Address [illegible] Date signed 10/1/45

1596 (Licensed Embalmer's Statement on Reverse Side)

MAR 3 1950

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 Chas L Zaring

Licensed Embalmer No. 4132

P. O. Address Columbia, Me

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.