

FILED FEB 21 1946

Registration District No. 128

Primary Registration District No. 5466

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Rural, S. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: OSKAR O. SEBASTIAN HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
In this community Native  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Ash Grove Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? — (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Eddie Swinney

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Single  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years  
7. Birth date of deceased 8 - 1887  
(Month) (Day) (Year)

8. AGE: Years 58 Months 5 Days 23 If less than one day  
hr. min.

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

10. Usual occupation Farm Helper  
11. Industry or business Farm Helper  
12. Name Mart Swinney  
13. Birthplace UNK. Ky. U  
(City, town, or county) (State or foreign country)  
14. Maiden name Sis. ARTH  
15. Birthplace UNK. Mo. U  
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Swinney  
(b) Address Ash Grove Mo.  
17. (a) Burial (b) Date thereof 2-2-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Johns Chapel

18. (a) Signature of funeral director Mary Swinney  
(b) Address Ash Grove Mo.  
19. (a) 2-1-46 (b) B. McHardy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31  
year 1946 hour 4 minute 15 A. M.

21. I hereby certify that I attended the deceased from Jan 24, 1946 to Jan 31, 1946, that I last saw him alive on Jan 30, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Toxemia Duration 4 wks.

Due to Malignant Disease of the Transverse & Descending Colon

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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 —  
(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 Thomas F. Matz (M. D. or other) MD.  
Address Ash Grove, Mo Date signed 1-31-46

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

17-39 X32873

**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 Glenn R. Larson

Licensed Embalmer No. 3297

P. O. Address Miller Mo.

**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.**

X

Registration District No. 128 Primary Registration District No. 5466

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Princeton, Campbell Twp.  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Eddie Swinney

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 4 1888  
(Month) (Day) (Year)

8. AGE: Years 58 Months \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Generalized Systemic Toxemia  
Due to Malignant Disease of the Colon (Adeno-Carcinoma)  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 462

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 Stover F. Matz (M. D. or other) pld  
Address Ashe Grove, MO Date signed 2-14-46

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

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2761