

S. No. 2
4-8-43
5-17-39
P 1 X37823

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED MAR 27 1946 STANDARD CERTIFICATE OF DEATH

State File No. **9115**
Registrar's No. **225**

Registration District No. **128** Primary Registration District No. **2000**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
59
2
4
0042

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Springfield Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 wks**
In this community **20 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene 39**
(c) City or town **Bois D Arc**
(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 **Bessie Swinney**
3. (b) If veteran, name war **UNK.** 3. (c) Social Security No. **UNK.**
4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Herbert Swinney** 6. (c) Age of husband or wife if alive **63** years
7. Birth date of deceased **7-17-1883**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **6**
year **1946** hour **6:00** minute _____ P. M.
21. I hereby certify that I attended the deceased from **Feb. 12**
19**46**, to **March 6**, 19**46**;
that I last saw her alive on **March 6**, 19**46**;
and that death occurred on the date and hour stated above.
Immediate cause of death **Strangulated Uterine Hernia**
Duration _____

8. AGE: Years Months Days If less than one day
52 **7** **29** hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **220**
Major findings: **uterine Strangulated Uterine Hernia**
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **Greene Co Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**
11. Industry or business _____

MOTHER FATHER
12. Name **Dock Hendrix**
13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Hedlearn**
15. Birthplace **Greene Co Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Herbert Swinney**
(b) Address **Bois D Arc, Mo.**
17. (a) **Burial** (b) Date thereof **3-9-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Prospect Cem**
18. (a) Signature of funeral director **Morris L. Leiman**
(b) Address **Ash Grove, Mo.**
19. (a) **3-9-46** (b) **Dr. W. H. Handy**
(Date received local registrar) (Registrar's signature)

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 **Dr. W. H. Handy** (M. D. or other) _____
Address _____ Date signed _____

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 Maude O Morris

Licensed Embalmer No. 2055

P. O. Address Ash Grove 190

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.