

FILED SEP 23 1946

Registration District No. 42

Primary Registration District No. 1000

State File No.

Registrar's No. 1040

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

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph's Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 hour 35 min.  
(Specify whether  
In this community 6 hr. 35 min.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town Industrial City  
(If outside city or town limits, write "RURAL")  
(d) Street No. rather about 2 miles  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Alice Jean Swape

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased (Month) 9 (Day) 11 (Year) 46

8. AGE: Years Months Days If less than one day  
0 0 0 6 hr. 35 min.

9. Birthplace St. Joseph Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation New born

11. Industry or business None

12. Name William John Swape

13. Birthplace St. Joseph Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Alta Mae Freeman

15. Birthplace Craig Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant William John Swape

(b) Address Industrial City

17. (a) BURIAL (b) Date thereof Sept-11-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. Olivet Cem.

18. (a) Signature of funeral director H.A. Sidenfaden & Son

(b) Address 1802 Union St. Joseph MO

19. (a) Sept. 17, 1946 (Date received local registrar)  
J. J. Nathaniel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 11  
year 1946 hour 7:25 minute AM

21. I hereby certify that I attended the deceased from Sept 11, 1946, to same, 1946  
that I last saw him alive on Sept 11, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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 W. C. Allaman (M. D. or other)  
Address City, Mo. Date signed 9/11/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

*not Embalmed*

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**