

FILED OCT 28 1946

1000

Registration District No.

Primary Registration District No.

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:
State Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days
In this community 48 years 11 months 11 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 816 South 17th St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Ralph John Swafford

3. (b) If veteran, name war No 3. (c) Social Security No. 491-09-3847

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 4 years (Day) (Year)

7. Birth date of deceased November 4 1897
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 11 11 hr. min.

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

10. Usual occupation Book-keeper

11. Industry or business.....

MOTHER FATHER { 12. Name Samuel Swafford
13. Birthplace Unknown Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Carrie Hackenlaible
15. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hosp # 2
(b) Address St Joseph, Missouri

17. (a) Burial (b) Date thereof 10/17/1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Walter Heierhoff
(b) Address 1302 Faraon, St. Joseph, Missouri

19. (a) Oct. 24, 1946 (b) W. J. Heierhoff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15
year 1946 hour 2 minute 10 A. M.

21. I hereby certify that I attended the deceased from September 24
1946 to October 15 1946
that I last saw him alive on October 14 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease, inactive, Chronic
Duration 5 yrs.

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) (c) Means of injury.....

23. Signature Delbert P Johnson (M. D. or other) M.D.
Address State Hosp # 12 Date signed 10/15/46

3/4

95B

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

MOTHER FATHER

OCT 7 1945

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.....

Albert C. Harrington

Licensed Embalmer No.

3258 Md

P. O. Address.....

St. Josephs

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.