

Registration District No. **72**

Primary Registration District No. **289**

1. PLACE OF DEATH:
 (a) County Clay
 (b) City or town Randolph, Missouri
 (c) Name of hospital or institution: Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
 In this community 40 years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Clay
 (c) City or town Randolph, Missouri
 (d) Street No. None
 (e) Citizen of foreign country? No
 If yes, name country X

3. (a) PRINT FULL NAME CHARLES VICTOR SWANSON
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Stella Swanson
 6. (c) Age of husband or wife if alive 76 years
 7. Birth date of deceased April 16 1863
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>11</u>	<u>3</u>	<u>X</u> hr. <u>X</u> min.

9. Birthplace Sweden Sweden
 (City, town, or county) (State or foreign country)

10. Usual occupation Section Forman, Retired RR

11. Industry or business Wabash Railroad

MOTHER FATHER

12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. (a) Informant Mrs Stella Swanson

(b) Address Randolph, Missouri

17. (a) Removal (b) Date thereof 3/20/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Novinger, Mo.

18. (a) Signature of funeral director Morton Smith's F.H.

(b) Address 832 Armour Rd. North Kans.

19. (a) Mar 20 - 47 (b) Baugh Kitchen
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
 year 1947 hour 7:00 AM/PM
 21. I hereby certify that I attended the deceased from Dec 1946 to March 19 1947
 that I last saw him alive on March 18 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis
 Due to _____
 Due to _____

Other conditions 132
 (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? _____
 (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 _____
 Signature J.W. Smith (M. D. or other) MD
 Address 3-19-47 Date signed _____

Duration 3 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

Registration Number

Date Filed

472-47

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

Chester H. Blum

, Registered Apprentice No.

447

working under my personal supervision.

Signed

Theron O. Smith

Licensed Embalmer No.

3928

P. O. Address

North New City, N.Y.

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.