

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town rural Hudson
(If outside city or town limits, write "RURAL" and name of township)

(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 _____
years, months or days

3. (a) PRINT FULL NAME Mary C. Swimmer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Dec 23 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER

12. Name George Long 4

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

14. Maiden name Cathy

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

16. (a) Informant Hurry Swimmer

(b) Address Macon, Mo.

17. (a) Burial (b) Date thereof 2-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director Stephen Woodbury

(b) Address Macon, Mo.

19. (a) 4-21-47 (b) With McNealy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. Macon R. 7-D. II.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1947 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from 5-25- 1946 to 2-8- 1947
that I last saw her alive on 2-7- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia Duration 3 weeks

Due to Chronic Bronchitis 2 yrs
Asthmatic Bronchitis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____ 107

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J.P. Cronway (M. D. _____)

Address Macon Mo Date signed 4/17/47

SEP 26 1955

RECEIVED

District Health Officer No.
District File Number 4-47-7
Date Filed APR 29 1947

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.....

O. L. Stephens

Licensed Embalmer No.....

3057

P. O. Address.....

Macon, 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.