

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33895

State File No. _____

Registration District No. 55

Primary Registration District No. 3011

Registrar's No. 237

1. PLACE OF DEATH:

(a) County CARROLL
(b) City or town CARROLLTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATON Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Bogard
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MAUDE LEE SWANK

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Jess Swank 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 6 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 4 27 hr. min. 0

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

10. Usual occupation HOUSE KEEPER

11. Industry or business _____

MOTHER FATHER
12. Name John TUCKER
13. Birthplace New York (City, town, or county) (State or foreign country)
14. Maiden name Shaban
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Jess Swank
(b) Address Carrollton, Mo RFD.

17. (a) Burial (b) Date thereof Oct 10 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TROTTER

18. (a) Signature of funeral director E. A. Dickerson

(b) Address Bogard Mo

19. (a) 10/10/47 (b) Dr. Herbert Calvert
(Date received local registrar) (Registrar's signature) 115

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 8 year 1947 hour 12 minute 07 A.M.

21. I hereby certify that I attended the deceased from Oct. 1 1947 to Oct 8 1947
that I last saw her alive on Oct 8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency
Due to Age + over work

Duration 3 yrs

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

Major findings: _____
Of operations 92B
Of autopsy _____

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? 0

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

23. Signature Dr. Hamilton Trotter M.D. or other _____
Address Carrollton, Mo Date signed Oct 11 1947

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed
Filed

10-24-47

AUG 14 1953

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

E. A. Dickinson

Licensed Embalmer No.

2534

P. O. Address

Logan M

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.