

FILED DEC 15 1947

Registration District No. **585**

Primary Registration District No. **3039**

Registrar's No. **145**

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

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Marceline
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 hrs.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Phillip Swinehart

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased: Nov 5 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 26 hr. 5 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Cecil G. Swinehart

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

14. Maiden name Helma Schroyer

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

16. (a) Informant Cecil Swinehart

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Nov 7 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation out Olivet

18. (a) Signature of funeral director James Mangham

(b) Address Marceline Mo

19. (a) 11-7-47 (b) L. E. Shuttles
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln 58
(c) City or town Marceline 2
(If outside city or town limits, write "RURAL") 1
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6
year 1947 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from Wed. Nov. 5, 1947 to Thurs. Nov. 6, 1947
that I last saw him alive on Nov. 6, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Premature birth Duration 26 hrs.

Due to _____

Due to _____

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

Major findings: Of operations 101

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 B. B. Hurst (M. D. or other) MD

Address Marceline, Mo. Date signed 11-7-47

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.

not Embalmed.

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.