

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10-48

FILED JAN 14 1952

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>17</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
d. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		<u>1396</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2009 N. Park</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANDREW</u>		b. (Middle) <u>G.</u>		c. (Last) <u>SWANSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 6, 1952</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Jan 18, 1860</u>	
9. AGE (In years last birthday) <u>91</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Peter Swanson</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Single</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Tille Swanson Springfield MO</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		ANTECEDENT CAUSES				<u>2 wks</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____					
		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Lymphatic leukemia</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>2040</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-1, 1951</u> , to <u>1-6, 1952</u> , that I last saw the deceased alive on <u>Jan. 6, 1952</u> , and that death occurred at <u>9:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>James H. Ans, M.D.</u>				23b. ADDRESS <u>304 Medical Arts Bldg</u>		23c. DATE SIGNED <u>1-7-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-8-1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo</u>	
DATE REC'D BY LOCAL REG. <u>1-8-52</u>		REGISTRAR'S SIGNATURE <u>James H. Ans, M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.W. Klingner & Co. Spfld. Mo.</u>		

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

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See Dr. Johnston

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Max Rhodes

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

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.