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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-043411
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 43 Primary Registration District No. — Registrar's No. 732

1. PLACE OF DEATH a. COUNTY Butler	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brosley Rt. I — Inside Limits Yes ☐ No ☒	c. CITY OR TOWN Brosley Rt. I 0120 — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b 25 years	d. STREET ADDRESS (If outside, give location) 5 Mile South East — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Oliver Middle Green Last Swain		4. DATE OF DEATH Month 12 Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH 1 - 31 - 1897
9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Jordon Swain	13b. MOTHER'S MAIDEN NAME Sofrona Barber	14. NAME OF HUSBAND OR WIFE Mrs. Flora Della Swain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 495-32-8134	17. INFORMANT Mrs. Flora D. Swain Address Brosley, Mo. Rt. I	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Sudden

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cause unknown

DUE TO (c) 7831

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1956, to Dec. 15, 1958 and last saw him alive on Dec. 15, 1958

Death occurred at 8:00pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. L. Kneibert M.D.	22b. ADDRESS Poplar Bluff Mo	22c. DATE SIGNED 12/30/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-28-1958	23c. NAME OF CEMETERY OR CREMATORY Browns Chapel
23d. LOCATION (City, town, or county) (State) Brosley, Missouri		
24. FUNERAL DIRECTOR Lloyd Russell ADDRESS Piggott, Arkansas	25. DATE RECD. BY LOCAL REG. 1/3/59	26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JAN 23 1959

BUTLER CO. HEALTH CENTER

FILE No.

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 .....Me....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Gerald W. Hoggard

Licensed Embalmer No. 1116

P. O. Address Piggott Ar

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.