

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Jackson

Township _____

or Village Blue Springs

or City _____ (NO. _____ St. _____ Ward) _____

Registration District No. 395File No. 2 41309Primary Registration District No. 4232Registered No. 52FULL NAME William G Swinney

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)DATE OF BIRTH Aug 21 1880
(Month) (Day) (Year)AGE 31 yrs. 4 mos. 3 ds. If LESS than 1 day, _____ hrs. or _____ min.?OCCUPATION (a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) 3-07BIRTHPLACE (City or town, State or foreign country) Jackson MissouriPARENTS
NAME OF FATHER J. L. Swinney
BIRTHPLACE OF FATHER (City or town, State or foreign country) va
MAIDEN NAME OF MOTHER Catherine Gore
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gene Swinney(ADDRESS) Blue SpringsFiled 12-25, 1914, E. S. Harris

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 24, 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec 18, 1914, to Dec 24, 1914, that I last saw him alive on Dec 21, 1914, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pericardial effusion
1914
(Duration) _____ yrs. _____ mos. 6 ds.
Contributory (SECONDARY) 11
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. G. Swinney M. D.
(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Hall Cemetery DATE OF BURIAL 12-25, 1914UNDERTAKER A. B. Webb ADDRESS Blue Springs

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

PLACE OF DEATH
 County Jackson
 Township Blue Spgs
 or Village
 or City

Registration District No. 395 File No. 41309
 Primary Registration District No. 4232 Registered No. 52
 St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Wm G. Swinney

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE W MARRIED W WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH 8/21, 1880 (Month) (Day) (Year)

AGE 31 yrs. 4 mos. 3 ds. If LESS than 1 day, hrs. or min.

OCCUPATION (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Kanawha Va

PARENTS
 NAME OF FATHER J. L. Swinney
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Nas
 MAIDEN NAME OF MOTHER Esther Swine
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Wm Swinney
 (ADDRESS) Blue Spgs

Filed 12-25, 1911 M. E. S. Harris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12/24, 1911 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12/18, 1911, to 12/24, 1911, that I last saw him alive on 12/24, 1911, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Tubercular Pneumonia
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Z. Smith M. D.
12-24, 1911 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence

PLACE OF BURIAL OR REMOVAL Will be buried DATE OF BURIAL 12/24, 1911
 UNDERTAKER W. Webb ADDRESS Blue Spgs

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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