

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

18011

1. PLACE OF DEATH

County Marion
 Township Springfield
 City Springfield (No. 896 N. Grant Ave.)

Do. Dist 318
 Registration District No. _____
 Primary Registration District No. 2001

File No. _____
 Registered No. 356
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 846 N. Grant Ave. Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 33 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widow</u>
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John A. Swanson</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec. 29 - 1898</u>		
7. AGE YEARS <u>68</u>	MONTHS <u>5</u>	DAYS <u>10</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Sweden

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Sweden

14. INFORMANT (Address) Oscar Walstrom
846 N. Grant Ave.

15. FILED 6/10-27 1927 Oct 1st REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-9-27

17. I HEREBY CERTIFY, That I attended deceased from 4/1 1927, to 6-9 1927, and that I last saw him/her alive on 6-9 1927, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral
apoplexy
74-21
 (duration) yrs. mos. da. 2 da.

CONTRIBUTOR Arterial Sclerosis
 (SECONDARY) several
 (duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) O. J. Frost M. D.
10 1927 (Address) Springfield Mo.

*State the DISEASE CAUSING DEATH, or if death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL CEMETERY East Lawn

20. DATE OF BURIAL 6-12-27

20. UNDERTAKER W. H. Harsh

ADDRESS Springfield Mo.

WHITE PAPER, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1927
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