

31 1928

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

Do not use this space.

8352

1. PLACE OF DEATH

County Dade Registration District No. 237 File No. _____
Township Center Primary Registration District No. 3323 Registered No. 21
City E. M. N.E. Greenfield _____ St. _____ Ward _____

2. FULL NAME Sarah Ann Swanger (County Jail)
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) _____ (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 25 1825
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
102 5 11
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Morroe Co.
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER Geo Davis

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

12. MAIDEN NAME OF MOTHER Matilda Carmichael

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

14. INFORMANT U. B. Travis
(Address) Seybert, Mo

15. FILED 3-6, 1928 E. O. Ball
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-6 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 162

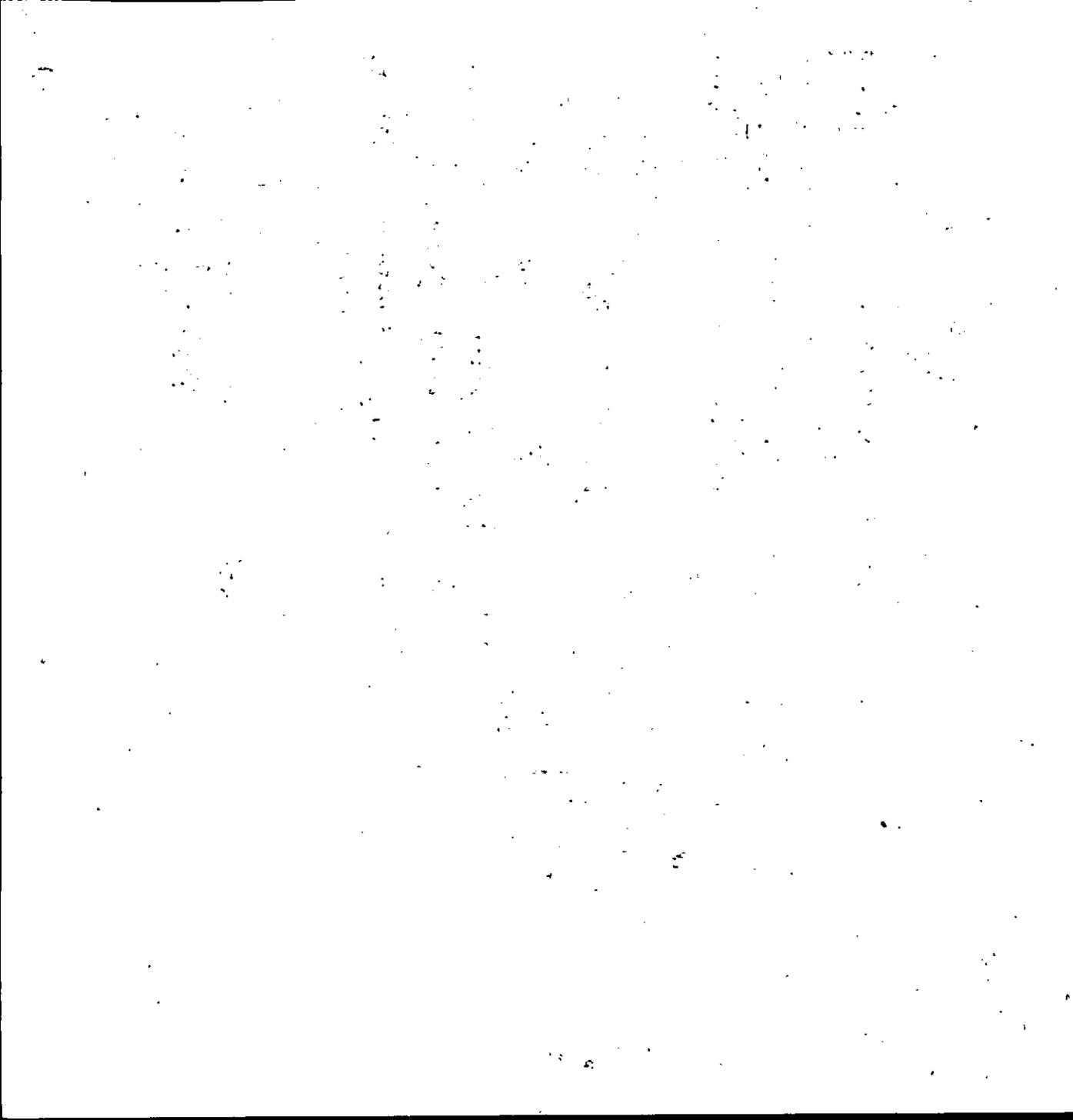
164 age 162
County Jail (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Patient (duration) yrs. mos. ds.
doctor

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) _____, M. D.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Lion Cem. DATE OF BURIAL Mar. 7 1928

20. UNDERTAKER J. W. Ward ADDRESS Greenfield Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wade Registration District No. 237 File No. _____
 Township Center Primary Registration District No. 5-323 Registered No. 21
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. mos. ds.
 (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) _____

PARENTS
 10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED 3-6-1928 CoBall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-6-1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) _____ yrs. mos. ds.

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY: Dr. A. Higgins, M.D.

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) Dr. Doctor (C. J. Farnham) M. D.

19 (Address) _____

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-8352