

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

Do not use this space.

14861

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

R003

File No.....

City.....

Registered No.....

3760

St.....

Ward.....

2. FULL NAME

(a) Residence. No.....

(Usual place of abode)

Length of residence in city or town where death occurred

St.....

Ward.....

ys.

mos.

ds.

How long in U.S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

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

April 1 - 1868

7. AGE

60

YEARS

MONTHS

2

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Crossing Floorman

(b) General nature of industry, business, or establishment in which employed (or employer)

Railway

(c) Name of employer

Missouri Pacific RR

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Leann

10. NAME OF FATHER

James Swink

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Leann

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

14.

INFORMANT

(Address)

W. J. Trotter
Mo Pacific Hosp

15.

FILED

18

Wm C. Starkey

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

April 3 1928

17.

I HEREBY CERTIFY That I attended deceased from Jan 19 1928 to April 3 1928

that I last saw him alive on April 2 1928, and that death occurred, on the date stated above, at 6 25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Embolism

Immediate (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis

Aberrant Ecdarthritis (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Jacob B. Gruber, M. D.

, 19 (Address) 1755 De Grand

*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

Monmouth, Ia.

4-5-1928

20. UNDERTAKER

ADDRESS

Peter Funerary Co

Monmouth Ia.

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.

THIS IS A PERMANENT RECORD

