

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

Do not use this space.

23312

1. PLACE OF DEATH

County Clay County Registration District No. 198
Township Washington Primary Registration District No. 3011
City Excelsior Springs Mo

File No. _____
Registered No. 74
St. _____ Ward _____

2. FULL NAME

Augusta Christina Swanson

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

Length of residence in city or town where death occurred — yrs. — mos. 17 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED OR DIVORCED (husband of OR) WIFE OF <u>Paul Axel Swanson</u> <u>Married</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 5 - 1870</u>				
7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>58</u>	<u>1</u>	<u>20</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Housewife</u> ^{139A}				
(b) General nature of industry, business, or establishment in which employed (or employer) <u>15E</u>				
(c) Name of employer <u>132!</u>				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 1928

17. I HEREBY CERTIFY, That I attended deceased from July 1928, to July 25 1928, and that I last saw her alive on July 25 1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uræmic Poisoning.

Probably about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cardiac decompensation

+ Relvic cyst (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: Believe Anamosa Iowa

DID AN OPERATION PRECEDE DEATH: Ramona DATE OF July 9 - 1928

WAS THERE AN AUTOPSY? NO.

WHAT TEST CONFIRMED DIAGNOSIS: Physical tests

(Signed) John J. Harris, M. D.
, 19 (Address) Excelsior Springs Mo.

*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.

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

10. NAME OF FATHER Paul Knoss

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

12. MAIDEN NAME OF MOTHER Paul Knoss

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

14. INFORMANT A. Swanson
(Address) Anamosa Iowa

15. FILED 7-25-28 J. D. Croves REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Belle Plaine Iowa DATE OF BURIAL July 27 1928

20. UNDERTAKER John C. Procher ADDRESS Excelsior Springs Mo

N. B.—Every item of information should state CAUSE OF DEATH in plain English. Do not classify. Do not abbreviate. Do not use initials. Do not use "Very Important."

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Clay Registration District No. 198 File No.
 Township Excelsior Springs Primary Registration District No. 3011 Registered No. 94
 City Excelsior Springs St. Ward)
 2. FULL NAME Augusta Christine Swanson
 (a) Residence No. St., Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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 4/10 1928 J. D. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 - 1928
 17. I HEREBY CERTIFY, that I attended deceased from 19....., to 19....., (that I last saw him after on 19....., and that death occurred, on the date stated above, at m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uterine Poisoning
ovarian cyst
 CONTRIBUTORY (SECONDARY) Cardiac De-compensation
& Pelvic Cyst (Benign)
 18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH..... DATE OF.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?..... (Signed) J. J. Gaines 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

REC-4 VE A FEE FOR CERTIFICATES UN IL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 Information should be carefully reviewed. GE should be stated EXACTLY. PHOTOCOPYING of this form is prohibited. All information on this form is confidential. No part of this information is to be distributed outside the Missouri State Board of Health. This form is to be used only for the purpose of reporting deaths. It is not to be used for any other purpose. It is the responsibility of the registrars to see that this information is properly reported. It is the responsibility of the registrars to see that this information is properly reported. It is the responsibility of the registrars to see that this information is properly reported.

SUPPLEMENTARY

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S-23312.