

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

Do not use this space.

458

1. PLACE OF DEATH

County Callaway
Township Fulton
City Fulton (No. _____) (St. _____) (Ward _____)

Registration District No. 134
Primary Registration District No. 3008

File No. _____
Registered No. 20

2. FULL NAME

Thomas J. Swearingin Jefferson City Mo.
(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. 8 da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widowed
(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.
75 — — — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman Coal Miner
(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 Medical Certificate
(Address) _____

15. FILED Jan. 26, 1929 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/17/29

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929 to Jan 17, 1929
that I last saw him/her alive on Jan 17, 1929 and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial Degeneration

CONTRIBUTORY (SECONDARY) Benign
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 900
IF NOT AT PLACE OF DEATH: _____ (duration) _____ yrs. _____ mos. _____ da.

DID AN OPERATION PRECEDE DEATH? 7/9/19 DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. E. Taylor M.D.
, 19 _____ (Address) State Hospital

*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.
Fulton Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jefferson City **DATE OF BURIAL** 1-19-29

20. UNDERTAKER Dawson Ganner **ADDRESS** Jefferson City

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.

122
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