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

Do not use this space.

7786

File No. 5

Registered No.

1. PLACE OF DEATH
County: St. Francois
Township: Bonne Terre
City: Flat River Mo. (No. ..... St. ..... Ward)
Registration District No. 774
Primary Registration District No. 4463

2. FULL NAME: Golda May Swaringim

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

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Herman

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 16-1893

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
35	1	17	

8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: Housewife
(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): Wain Co. Mo.

PARENTS

10. NAME OF FATHER: Elijah Bennett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Wain Co. Mo.
12. MAIDEN NAME OF MOTHER: Eliza Tidwell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Wain Co. Mo.

14. INFORMANT: Herman Swaringim
(Address): Flat River Mo.

15. FILED: Feb. 13, 1929. F. L. Keith, REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 3 — 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-2, 1929, to 1-2, 1929, that I last saw her alive on 1-2, 1929, and that death occurred, on the date stated above, at 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Endocarditis and Myocarditis
9 10 (duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (SECONDARY) Measles ?
? (duration) ..... yrs. ..... mos. ? ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH At place of death
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) F. P. DeHoney, M. D.
, 19 (Address) Flat River 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Pilot Knob
DATE OF BURIAL: Feb. 6 1929

20. UNDERTAKER: C. J. Boyer
ADDRESS: Desloge Mo

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.