SEP 24 1929

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

Do not use this space.

27268

1. PLACE OF DEATH
County Clay — Registration District No. 198 — File No.
Township — Primary Registration District No. 3011 — Registered No. 108
City Excelsior Springs — St. — Ward)

2. FULL NAME Bessie Alice Swafford

(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)
Female	white	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 2 - 1886

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
43	—	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Rayville
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER A. J. Martin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rayville
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Eliza Clark
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Rayville
(STATE OR COUNTRY) Mo

14. INFORMANT Chester Martin
(Address) Rayville Mo

15. FILED 8/22 1929 Y. D. Crowell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 22 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug. 22, 1929 that I last saw her alive on Aug 22, 1929, and that death occurred, on the date stated above, at 11 - a - m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis
220
(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Dan Knox
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Rayville Mo
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) John F. Gray, M. D.
Aug. 22, 1929 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Crowley Cemetery	Aug. 23, 1929
20. UNDERTAKER E. Hunman	ADDRESS Richmond Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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