

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

Do not use this space.

399
235
2
31

1. PLACE OF DEATH

County..... Jackson Registration District No. 399
Township..... Kaw Primary Registration District No. 1002
City..... Kansas City (No. 4662 East 37th Street Terrace St. Ward)

File No.
Registered No.

2. FULL NAME Mary Jane Swank

(a) Residence. No. 4662 East 37th St. Terrace 16 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 Walter M. Swank

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby. 5, 1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	56	6	2	

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

9. BIRTHPLACE (CITY OR TOWN)..... Seamore
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Benton A. Joiner

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) not known

14. INFORMANT..... Walter T. Swank
(Address) 4662 East 37th Terrace

15. FILED..... 8/8/29 M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 7 19 29

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral embolism
46c
45
(duration) yrs..... mos..... ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) W. M. Crowe M. D.
8/8 19 29 (Address) Kansas

*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.....
St. Joseph, Missouri 8/8 19 29

20. UNDERTAKER..... ADDRESS.....
Blue + Mc. Clure 3235 William
Place

WRITE PAINLY, 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.

