

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

Do not use this space.

43170

1. PLACE OF DEATH

County Stoddard
Township Castor
City (No. _____) _____

Registration District No. 837
Primary Registration District No. 0699

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

2. FULL NAME

Rube Swallows

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-10-1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>54</u>	<u>10</u>	<u>8</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) Indiana

10. NAME OF FATHER Not known

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 Edw. Ford
(Address) Bloomfield Mo.

15. Jan 7 1930 Edw. Ford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-18 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1929, 1929, to Dec 18 1929, 1929, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 4:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Lobular

107A
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 107A
(duration) _____ yrs. _____ mos. _____ ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. W. Biny, M. D.
, 19 (Address) Bloomfield 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 Walters Cemetery DATE OF BURIAL 12-19 1929

20. UNDERTAKER J. A. Childs ADDRESS Bloomfield

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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