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

Do not use this space.

25599

1. PLACE OF DEATH
County Shelby Co. Registration District No. 830 File No. 21
Township Salt Rive Primary Registration District No. 6091 Registered No.
City ~~Shelbina~~ Mo. (No. St. Ward)

2. FULL NAME Wm. T. Swearingen

(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 26-1848.

7. AGE: Years 81 | Months 11 | Days 7 | If LESS than 1 day, hrs. or min.

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

PARENTS
10. NAME OF FATHER Thomas Swearingen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co. Mo.
12. MAIDEN NAME OF MOTHER Polly Ashcroft
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. H. R. Keith
(Address) Shelbina Mo.

15. FILED July 10, 1930 Madge Gooch REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3 1930

17. I HEREBY CERTIFY, That I attended deceased from last two years, 19, to, 19, that I last saw him alive on June 19, 1930 and that death occurred, on the date stated above, at 12.45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Parenchymatous Nephritis
131
162 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) — Advanced Age
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical history
(Signed) J. D. Smith, M.D.
, 19 (Address) Shelbina 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: I. O. O. F. Shelbina Mo. DATE OF BURIAL: July 5, 1930

20. UNDERTAKER: J. B. Brothers ADDRESS: Shelbina 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.