

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

Do not use this space.

#208
4208-A
File No. _____
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Leath
Township Jornfelt
City Jornfelt (No. _____)

Registration District No. 11576
Primary Registration District No. 4578

2. FULL NAME Fattie Cynthia Swinney

(a) Residence. No. _____ St. _____
(Usual place of abode) _____
Length of residence in city or town where death occurred 1 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 Sam Swinney

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 11, 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 3 26

8. OCCUPATION OF DECEASED
(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) Craighead Co Ark
(STATE OR COUNTRY)

10. NAME OF FATHER William Mead

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Edna Hester
(Address) Jornfelt Mo.

15. FILED 1-8 1931 R. A. Gorman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7, 1931

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
Jan 2 1931 to Jan 7 1931
that I last saw him alive on Jan 7, 1931, and that death occurred, on the date stated above, at _____ a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia
108 (duration) yrs. _____ mos. 7 ds.
CONTRIBUTORY (SECONDARY) 108 (duration) yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) G. J. D. D. M. D.
1-8 1931 (Address) Illness. case.

*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 Lightner Cemetery DATE OF BURIAL Jan 9, 1931
20. UNDERTAKER W. H. Hubbard ADDRESS Illness 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.

WHILE I LIVE, WITH WRITING THEREON, THIS IS A PERMANENT RECORD

