

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

Do not use this space.

37868

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Blue Primary Registration District No. _____
City Beeds (No. K.C. TB Hospital)

File No. _____
Registered No. 2000
St. 2000 Ward _____

2. FULL NAME

Swigg, Ethel

(a) Residence. No. 2954 Crystal St., X Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 - 1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 3 15

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) Ashley
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Merical Homer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Carr, Mildred

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo.

14. INFORMANT K. C. T. Hospital
(Address) Beeds, Missouri

15. FILED 11/27/31 M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 25 1931

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1931, to Nov. 25, 1931, that I last saw h. at alive on Nov. 25, 1931, and that death occurred, on the date stated above, at 11:20 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23 23A
(duration) yrs. 6 mos. da.

CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) W. H. ..., M. D.
11/25, 1931 (Address)

*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 Blue Ridge Lawn Cemetery DATE OF BURIAL 11-28-31

20. UNDERTAKER Flynn + Greenstreet ADDRESS K.C. 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.

