

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

Do not use this space.

16461

1. PLACE OF DEATH
 County Jackson Registration District No. _____
 Township Raw Primary Registration District No. _____
 City Kennett Mo (No. Mercy Hosp) _____ St. _____ Ward _____

File No. _____
 Registered No. 1946
 _____ St. _____ Ward _____

2. FULL NAME Dorothy Swafford
 (a) Residence. No. Madette, Mo. 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 Fe
 4. COLOR OR RACE wh
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-1-1929
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
34 1 3
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Child
 (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) Arkansas

PARENTS
 10. NAME OF FATHER Albert Swafford
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Arkansas
 12. MAIDEN NAME OF MOTHER Opal Standaer
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Arkansas

14. INFORMANT Wm. H. Crover
 (Address) Albert Swafford

15. FILED May 4 1933 Wm. H. Crover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4 1933
 17. I HEREBY CERTIFY, That I attended deceased from 3-10-33, 1933, to 5-4-33, 19____, and that I last saw h.c.r. alive on 5-4-33, 19____, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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 (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? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) C. E. Dummick, M. D.
74 .1933 (Address) Mercy Hosp
 *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 Monett Mo DATE OF BURIAL May 4 1933

20. UNDERTAKER Quirk & Tassin Co ADDRESS 2000 Lincoln

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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