

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

Do not use this space.

36290

1. PLACE OF DEATH

County Harrison Registration District No. 334
 Township _____ Primary Registration District No. 4197
 City Bethany (No. _____, St. _____, Ward _____)

2. FULL NAME Ada Viola Swigart

(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. 2 mos. da. 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) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elza Swigart

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 25, 1887

7. AGE YEARS 46 MONTHS 8 DAYS 12 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrison Co., Mo.

13. NAME William Conley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Sarah E Burns

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) PA.

17. INFORMANT Mrs Sarah E Tripp (ADDRESS) Bethany, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Eagleville, Mo. DATE 11/9, 1933

19. UNDERTAKER W. J. Harned (ADDRESS) Bethany, Mo.

20. FILED 11-10 1933 W. J. Harned Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 7 - 1933

22. I HEREBY CERTIFY, That I attended deceased from Nov 6 1933, to Nov 7 1933

I last saw him alive on Nov 7 1933 Death is said

to have occurred on the date stated above, at 12:05 P M

The principal cause of death and related causes of importance were as follows:

Cerebral Abscess Date of onset _____

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Other contributory causes of importance: _____

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) D. J. Reed D.O., M. D.

(Address) Bethany, Mo.

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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