

SEP 28 1938

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

30297
Do not use this space.

1. PLACE OF DEATH

(a) County North
(b) Township Alle-
(c) City Grant City, Mo

Registration District No. 903
Primary Registration District No. 454.5

Registered No. _____

(e) Length of residence in city or town where death occurred

(d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

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

9. Industry or business in which work was done, as 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE Brairie Chapel DATE 9/6 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED

9-9

19. 38

807

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/6 1938

22. I HEREBY CERTIFY, That I attended deceased from Sept. 4 1938 to Sept 5 1938

I last saw him alive on Sept 5 1938 Death is said to have occurred on the date stated above, at 5 AM.

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

Date of onset

Heart Failure
Protein compensation

Other contributory causes of importance:

Name of operation Farm 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? _____

If so, specify _____

(Signed) J. J. Swift M. D.

(Address) Grant City Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

Arch C. Dunfee

, or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Arch C. Dunfee

Licensed Embalmer No.....

3252

P. O. Address.....

Hunt City, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.