

1875
REC'D AUG 7 1939

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

27119
Do not use this space.

1. PLACE OF DEATH

(a) County Warren Registration District No. 875
(b) Township Washington Primary Registration District No. 6162 Registered No. 169
(c) City Neosho (d) Street No. St. Hospital no. 3 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. Route 1 Bois D'Arc MO 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 M 4. COLOR OR RACE W 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) Oct. 16-1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 8 28

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. Farmer
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) Green Co Mo

FATHER 13. NAME Jasper Sweeney

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

MOTHER 15. MAIDEN NAME Rebecca Jane Southard

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

17. INFORMANT (ADDRESS) R. W. Sweeney
Bois D'Arc MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE John Chapel DATE 7-16-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Warren & Senior
Miller MO.

20. FILED July 15, 1939 Allen V. Hays Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-15 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-8 1939, to 7-15 1939

I last saw him alive on 7-15 1939. Death is said

to have occurred on the date stated above, at 5:05 am.

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

Obstruction of Stomach Date of onset 6-26-39

Other contributory causes of importance:
Psychosis - Drug Addiction

Name of operation Electrolysis Date of 7-3-39

What test confirmed diagnosis? X-ray Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? None Date of injury 7-15-39

Where did injury occur? Home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased?

If so, specify None

(Signed) [Signature] M. D.
795 (Address) State Hospital #3
Neosho Mo.

1022

RECEIVED

District Health Officer No. 7,

District File Number 7-39-112

Date Filed 8-3-39

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed L. R. Luman

Licensed Embalmer No. 3297

P. O. Address Miller M.

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

27119

Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875-
(b) Township Washington Primary Registration District No. 6162
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 169

2. PRINT FULL NAME Fred A. Swinney

(a) Residence, No. SP (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (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.
44 8 29

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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-15-1939

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Obstruction of ileum
W. M. D. 1726
Other contributory causes of importance:
Phylloxera - Drug addiction

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

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 F. C. Lourey, M. D.
(Signed) Hoap # 3 (State)
(Address) Hoap # 3 (State)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY

1939
S-27119