DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7684

Registration District No. 62

Primary Registration District No. 5880

Registrar's No.

1. PLACE OF DEATH:

(a) County Perry

(b) City or town Rural

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution V

(Specify whether

In this community

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. 0

(If rural, give location)

(e) If foreign born, how long in U. S. A.? years

8. (a) PRINT FULL NAME 500 Walter Swann

8. (b) If veteran, name war

8. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Allie Swann

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April (Month) 9 (Day) 1868 (Year)

8. AGE: Years	Months	Days	If less than one day
71	9	24	hr. min.

9. Birthplace Perry Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name John Swann

13. Birthplace North Carolina (City, town, or county) (State or foreign country)

14. Maiden name Seina Sanlin

15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robt Swann

(b) Address Perryville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Shiloh (Perry Co. Mo

18. (a) Signature of funeral director Younger Bros.

(b) Address Perryville Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3 year 1940 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from 3-1-39 to 2-3- 19 40 that I last saw h alive on 9-11- 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Endocarditis (Chronic)	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) None	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature G A Galasch (M. D. or other)

Address Troma Mo. Date signed 2-4-40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 I X19511

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.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Edward C Young

Licensed Embalmer No. 2135

P. O. Address Kenneth Mo.

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.

No. 2B
2-21-40
1 X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7684

Registration District No. 662 Primary Registration District No. 5880 Registrar's No.

1. PLACE OF DEATH:
(a) County Perry (b) ~~City or town~~ Salem Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME Walter Swann

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days 24 If less than one day hrs. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4-13-40 (Date received local registrar) (b) W. A. Abernathy (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. G. Pelich (M. D. or other)
Address Farmington Date signed