

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.

Missouri Abstract 7-1540

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

8411  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Taney Registration District No. 859  
 (b) Township China Primary Registration District No. 6130 Registered No. 9  
 (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. mo. da. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mo. da.

2. PRINT FULL NAME Nelson McFlain Swador  
 (a) Residence, No. N. 2nd St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 17 1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>4</u>	<u>19</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) Stoddard Co Mo

FATHER  
 13. NAME Marcelline Swador  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bordeaux France

MOTHER  
 15. MAIDEN NAME Mary Gline  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) John Swador  
Mounds, Okla

18. BURIAL, CREMATION, OR REMOVAL PLACE Mounds Okla DATE 2-7-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Whelchel Fun Home  
Trancon, Mo

20. FILED 2-5-40 John M Baxter  
Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 4 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 3 1940 to Feb 4 1940  
 I last saw him alive on Feb 4 1940 Death is said to have occurred on the date stated above, at 2:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Hemorrhage of the brain  
arterio-sclerosis  
 Date of onset Feb 1 1940

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 none  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Dr. E. C. Giltner, M. D.  
 (Address) Trancon, Mo

RECEIVED

District Health Officer No. 6,

District File Number 340-626

Date Filed MAR 5 1940

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**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 *P. J. Hornhill*

Licensed Embalmer No. 2641

P. O. Address *Bramon 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.**