

SEP 25 1940
Registration District No. 799

Primary Registration District No. 6043

Registrar's No. 39

1. PLACE OF DEATH *Saline Mo*

(a) County *Saline*

(b) City or town *Preston Clay Mo*
(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 *2*
In this community *70 years* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Saline*

(c) City or town *Preston*
(If outside city or town limits, write "RURAL")

(d) Street No. *State Mo R 70A*
(If rural, give location)

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

3. (a) PRINT FULL NAME *Elvira Swisher*

3. (b) If veteran, name war _____

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug* day *7*
year *1940* hour *10:00* minute *45 A.M.*

4. Sex *female*

5. Color or race *white*

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive *5* years

7. Birth date of deceased *July 2 3-1845*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *July 10* 1936 to *Aug 7* 1940
that I last saw her alive on *Aug 7* 1940
and that death occurred on the date and hour stated above.

8. AGE: Years *95* Months *0* Days *14* If less than one day _____ hr. _____ min.

9. Birthplace *Weston Platte Co Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation *House Wife*

Immediate cause of death *Senility*

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

MOTHER FATHER

11. Industry or business _____

12. Name *Harvey Hedges*

13. Birthplace *Virginia*
(City, town, or county) (State or foreign country)

14. Maiden name *Married Swisher*

15. Birthplace *Marion Mo*
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant *Mrs Clarence Pable*

(b) Address *State Mo R 70A*

17. (a) ~~Signature~~ (b) Date thereof *8-9-40*
(Month) (Day) (Year)

(c) Place: burial or cremation *New Horton Mo*

18. (a) Signature of funeral director *Wm Jones*

(b) Address *Wm Jones*

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

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? *109*
While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature *Ed A. Duffell* (M. D. or _____)
Address *Saline Mo* Date signed *8-10-40*

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-11-10

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.