

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **821** Primary Registration District No. **4253** Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Scott
 (b) City or town Sikeston
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 3 weeks years, months or days)

3. (a) PRINT FULL NAME John Anderson Swinney **500**
 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 _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If
 alive _____ years
 7. Birth date of deceased 5 17 40
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 25 If less than one day
 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name Morton Swinney
 13. Birthplace Chester Mo. (City, town, or county) (State or foreign country)
 14. Maiden name Jessie May Baker
 15. Birthplace New Madrid Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jessie May Baker
 (b) Address 215 N. Ramsey Sikeston Mo.

17. (a) Burial (b) Date thereof 6-13-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director Hunter Albritton
 (b) Address Sikeston Mo.

19. (a) 8-6-40 (b) W. N. Crumell
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Scott
 (c) City or town Sikeston
 (If outside city or town limits, write "RURAL")
 (d) Street No. 215 N. Ramsey
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ year.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11
 year 1940 hour 12:00 minute _____ PM.

21. I hereby certify that I attended the deceased from May 27 1940 to June 11 1940
 that I last saw him alive on June 11 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Deafness
 Duration _____

Due to _____
 Due to 34

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

Major findings: Of operations _____
 Of autopsy none
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) none
 (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?
142 (Specify type of place) (e) Means of injury _____
 While at work? _____

23. Signature W. Anderson (M. D. or other) _____
 Address Sikeston Date signed 7-7-40

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.

RECEIVED

District Health Officer No. 2

District File Number 840-131

Date Filed 8/7/40

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

not embalmed Registered Apprentice No. _____
working under my personal supervision.

Signed John A. [Signature]

Licensed Embalmer No. 2941

P. O. Address [Signature]

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.