

STANDARD CERTIFICATE OF DEATH

State File No.

32720

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Madaway Missouri
 (b) City or town Maryville Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community all of life
 years, months or days

3. (a) PRINT FULL NAME

Arthur Oliver Swinford3. (b) If veteran,
name warNo

8. (c) Social Security

No. 495-10-61894. Sex Male5. Color or
race White6. (a) Single, widowed, married
divorced Single6. (b) Name of husband or wife None

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

Feb - 4 - 1919
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

21 8 14 hr. min.

9. Birthplace

Maryville Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name William Swinford13. Birthplace Maryville Missouri
(City, town, or county) (State or foreign country)14. Maiden name Maggie Elizabeth Crawford15. Birthplace Berman Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Maggie Swinford

(b) Address

1418 East Jenkins Maryville Mo17. (a) Burial
(Burial, cremation, or removal)(b) Date thereof Feb 28 1940
(Month) (Day) (Year)

(c) Place: burial or cremation

Oak Hill

18. (a) Signature of funeral director

Campbell Funeral Home

(b) Address

95 1/2 South Main Maryville Mo19. (a) Sept 19 40
(Date received local registrar)(b) Messrs E. Clardy
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Madaway
 (c) City or town Maryville Missouri
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1418 East Jenkins
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17
year 1940 hour 11 minute 45 P. M.21. I hereby certify that I attended the deceased from Sept 17
1940 to Sept 17 1940that I last saw him alive on Sept 17 1940
and that death occurred on the date and hour stated above.Immediate cause of death Concussion

Duration

of trainDue to Automobile accident

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy no

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically

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

- (a) Accident, suicide, or homicide (specify) Automobile
 (b) Date of occurrence Sept 17-1940
 (c) Where did injury occur? Near Farrell Mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Highway
 While at work? No (Specify type of place) (e) Means of injury _____

23. Signature H. M. Auelis (M. D. or other) M DAddress Maryville Date signed 9/15/40

210 m

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.....

William Campbell....., Registered Apprentice No.....
working under my personal supervision.

Signed: *William Campbell*.....

Licensed Embalmer No. *2620*

P. O. Address: *Marionville 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.

2B
21-40
X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32720**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **625**

Primary Registration District No. **3031**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Nodaway**
(b) City or town **Marysville**
(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
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Arthur Oliver Swinford**

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 **A**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years **21** Months **7** Days **14** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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.

20. DATE OF DEATH: Month **Sept** day **17** year **1940** hour _____ minute _____ M.

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

Immediate cause of death **Concussion of**

brain
Automobile accident

Due to **Accidental, car supposed to hit soft place in gravel and turned over, no collision.**
Other _____ (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) **Accident**

(b) Date of occurrence **Sept. 17, 1940**

(c) Where did injury occur? **Near Parnell Nodaway Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Highway No. 46.**

While at work? **no** (Specify type of place) (e) Means of injury **car turned over**

23. Signature **W. M. Hallie** (M. D. or other)
Address **Marysville, Mo.** Date signed _____

SUPPLEMENTAL

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

MOTHER FATHER

