

No. 2
X 23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1830
Registrar's No. 60

Registration District No. 85 Primary Registration District No. 1001

11
1
7
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST-JOSEPH
(c) Name of hospital or institution:
10031-GREEN
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community APT 40 YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County BUCHANAN
(c) City or town ST-JOSEPH
(If outside city or town limits, write "RURAL")
(d) Street No. 1003-GREEN-STR.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME ROBERT-GALE-SWARTHOUT

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Effie Swarthout 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased: aug 9 1870 (Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter

11. Industry or business _____
12. Name Ira D. Swarthout
13. Birthplace Missouri (City, town, or county) Missouri (State or foreign country)
14. Maiden name Anna B. Kintz
15. Birthplace Missouri (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Gerald Swarthout
(b) Address R. 2, D. #3

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Jan 18 1941 (Month) (Day) (Year)
(c) Place: burial or cremation St. Ambrose Cem

18. (a) Signature of funeral director Ray Stamey
(b) Address 2224 S. 1st

19. (a) Jan 15 1941 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JAN day 14 year 1941 hour 12 minute 00P M.

21. I hereby certify that I attended the deceased from 1/14, 1941, to 1/14, 1941 that I last saw him alive on 1/14/41 and that death occurred on the date and hour stated above.

Immediate cause of death White Angioplastin Duration 4 hrs

Due to _____

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 statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) NO
(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? 85

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address 2224 S. 1st Date signed 1/15/41

1189

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.....

Jan 14, 1941

Registered Apprentice No.....

working under my personal supervision.

Signed.....

John H. Hurley

Licensed Embalmer No. *40520*

P. O. Address *St. Joe*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1830

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85

Primary Registration District No. 100.1

Registrar's No. 60

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(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)

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 Robert Gale Swarthout

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month Jan day 14 year 1971 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.

4. Sex m 5. Color or race w

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

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) _____

Immediate cause of death acute indigestion Duration 1 1/2 hrs

Due to Gastroenteritis

Due to _____

Other conditions 1200
(include pregnancy within 3 months of death)

8. AGE: Years 70 Months 5 Days 5 If less than one day _____ hr _____ 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 _____

(b) Date thereof _____
(Month) (Day) (Year)

17. (a) Method of disposal _____
(Burial or removal)

(b) Date of cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-3-1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature J. S. Slawey (M. D. or other) _____

Address 2624 St. Joseph Date signed 3/29/71

SUPPLEMENTAL

