

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2384

Registration District No. 241

Primary Registration District No. 5238

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Dallas  
 (b) City or town Buffalo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Polk  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2 miles southeast of Buffalo  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Rosie May Swift  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife Charles Lee Swift  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 2 1880  
 (Month) (Day) (Year)

8. AGE: Years 60 Months 10 Days 4  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation house wife

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
 12. Name John L. Lamm  
 13. Birthplace Peoria Illinois  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Margaret Linn  
 15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lie Swift  
 (b) Address London Mine  
 17. (a) Burial (b) Date thereof Jan 8 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Hutchison & Co.  
 (b) Address Bohlar Missouri  
 19. (a) \_\_\_\_\_ (b) Harry Maxwell  
 (Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month January day 6th  
 year 1941 hour 10 minute 0 A. M.  
 21. I hereby certify that I attended the deceased from on  
Dec 20, 1940, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw her alive on Dec 20, 1940,  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Carcinoma Stomach  
 Due to \_\_\_\_\_  
46  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
none

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
 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?  
 \_\_\_\_\_  
 \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_  
 23. Signature E. L. Lamm (M. D. or other) \_\_\_\_\_  
 Address Buffalo MO Date signed 1-8-41

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.

*Proffers*  
*Monroe*

RECEIVED  
District Health Officer No. 7,  
District File Number 1-41-131  
Date Filed 1-14-41

**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 Bert Legan  
Licensed Embalmer No. 3979  
P. O. Address Bolivar, 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.**

o. 2B  
-21-40  
JUL 1918

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 2384

Registration District No. 241

Primary Registration District No. 0334

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dallas  
(b) City or town Benton T.P.  
(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 Rose May Swift  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
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 60 Months 10 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Dallas Co. Mo (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 \_\_\_\_\_

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) Mar 27 1941 (b) Henry M. Mow  
(Date received local registrar) (Registrar's signature)

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 Jan day 6  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 G. C. Plummer (M. D. or other)  
Address Buffalo Mo Date signed \_\_\_\_\_

Duration  
\_\_\_\_\_  
PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

