

FILED FEB 17 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

3389

## 1. PLACE OF DEATH

County Marion Registration District No. 547 File No. \_\_\_\_\_  
 Township Mason Primary Registration District No. 3029 Registered No. 29  
 City Hannibal (No. Levering Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Lulu May Swarngin

(a) Residence, No. R.F.D. # 1 St. \_\_\_\_\_ Ward 1  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C.F. Swarngin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS 69 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. own home  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Michigan

13. NAME W.H. Kidd

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) White Pigen Michigan

15. MAIDEN NAME Agatha Groat

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

17. INFORMANT C.F. Swarngin  
 (ADDRESS) R.F.D. # 1 Hannibal

18. BURIAL, CREMATION, OR REMOVAL

PLACE Mount Olivet DATE 1/18/41

19. UNDERTAKER Terrell Smith  
 (ADDRESS) 902 Broadway Hannibal

20. FILED Jan. 20, 1941 W.C. Fisher  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 16, 1941

22. I HEREBY CERTIFY that I attended deceased from Jan 16 1941, to Jan 17 1941

last saw him alive on Jan 17, 1941. Death is said to have occurred on the date stated above, at 12:50 A.M.

The principal cause of death and related causes of importance were as follows:

Angina pectoris Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Chronic myocarditis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) W.C. Fisher M. D.

(Address) 1001 1/2 N. Main St. Hannibal Mo

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.

D.W. Fisher

This body was embalmed by *James A. Moles*

License number 3296

Registration District No. 247

Primary Registration District No. 3029

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

1. PLACE OF DEATH:

(a) County Mason  
(b) City or town Hammond  
(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 Lulu May Swearingin

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

4. Sex 7 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 Unknown  
(Month) (Day) (Year)

8. AGE: Years about 69 Months \_\_\_\_\_ Days \_\_\_\_\_ 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 \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) E. M. Lucala  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 14  
year \_\_\_\_\_ 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 \_\_\_\_\_

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 J. Reichman \_\_\_\_\_ (or other) \_\_\_\_\_

Address Hammond \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

