

FILED JUN 13 1948

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

Do not use this space.

1. PLACE OF DEATH

County E. Polk  
Township E. Looeey  
City Brighton (No. 1)

Registration District No. 707  
Primary Registration District No. 5-9-36

File No. 18750  
Registered No. 10  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cora B. Swadley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 25 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
65 9 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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) Greene Co. Mo.

13. NAME Moses Robertus DePriest Swadley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Idaho

15. MAIDEN NAME Elizabeth Noble

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Idaho

17. INFORMANT M. A. Brock  
(ADDRESS) Brighton Rt. 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Ha Zelwood Cem. DATE Aug. 19 1935

19. UNDERTAKER Willard B. Erwin Fun. Home  
(ADDRESS) Pleasant Hope, Mo.

20. FILED Aug. 28 1935 Mrs. Hattie M. Taylor  
Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 17 1935

22. I HEREBY CERTIFY, That I attended deceased from Aug. 13 1935, to Aug. 16<sup>th</sup> 1935  
I last saw him alive on Aug. 16<sup>th</sup> 1935. Death is said to have occurred on the date stated above, at 10 P.M.

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

Paralysis  
Hemorrhage left hemisphere of brain

Date of onset Aug 13

Other contributory causes of importance: g3 p

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. E. Albricht M. D.  
(Address) Pleasant Hope, Mo.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. - Exact statement of cause of death.

84  
0  
0

RECEIVED

District Health Officer No. 7,

District File Number 6-41-1018

Date Filed 6-11-41

Registration District No. 707

Primary Registration District No. 5936

1. PLACE OF DEATH:  
(a) County Polk  
(b) City or town Leone  
(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 Missouri (b) County Polk  
(c) City or town Brighton  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Robertus Swadley  
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 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)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 18  
year 1943 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) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
65 9 22 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) Aug-10-1944 (b) Helen E. Dickinson  
(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 W. E. Albright (M. D. or other) \_\_\_\_\_  
Address Shasant Hope Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

S-18750 1941

1941-1942  
S-18750