

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

MAR 18 1942  
10836

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED APR 15 1942

State File No. ....

Registration District No. 377

Primary Registration District No. 4192

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town Republic Mo  
 (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: 1  
 (Specify whether  
 In this community 15 or 16 yrs  
 years, months or days)

3. (a) PRINT FULL NAME Charles L Swenson

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife wife deceased 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

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

9. Birthplace Schlesinger Halstern Germany  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farm

12. Name Peter

13. Birthplace Schlesinger Halstern Germany  
 (City, town, or county) (State or foreign country)

14. Maiden name Ida

15. Birthplace widow Mann  
 (City, town, or county) (State or foreign country)

16. (a) Informant Clara - Daughter

(b) Address Republic Mo

17. (a) Interment (b) Date thereof Mar 17-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greene Cemetery

18. (a) Signature of funeral director W E Mc...

(b) Address Republic Mo

19. (a) Mar 20-42 (b) Flourine Britain  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 039  
 (c) City or town Republic 0  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13  
 year 1942 hour 8:30 minute P M.

21. I hereby certify that I attended the deceased from February 1, 1942, to March 13, 1942  
 that I last saw him alive on March 12, 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of Heart  
 Due to no known cause

Other conditions (Include pregnancy within 3 months of death) 95c4

Major findings: Of operations none Of autopsy none

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) 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? \_\_\_\_\_

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

23. Signature E L Seal (M. D. number) 0  
 Address Republic Mo Date signed 3/13-42

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

MOTHER FATHER

RECEIVED

Orange County Health Office

County File Number 42-4-70

Date Rec'd 4/13/42

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 *C. P. [Signature]*

Licensed Embalmer No. 509

P. O. Address Republic [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 10836

Registration District No. .... Primary Registration District No. .... Registrar's No. ....

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic  
(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 years, months or days)

In this community 16 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

(c) City or town Republic  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Charles L. Swenson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 12 Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Month) (Day) (Year)

7. Birth date of deceased Mar - 9 - 1872

8. AGE: Years 70 Months 11 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 \_\_\_\_\_

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (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) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

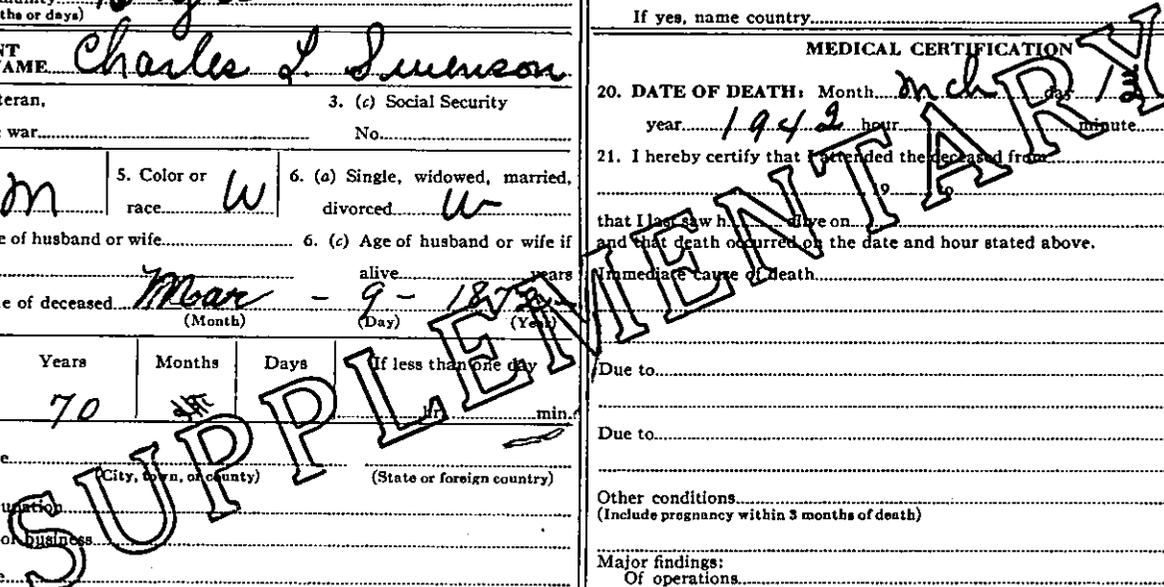
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(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 \_\_\_\_\_ (M, D. or other) \_\_\_\_\_ Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



5-10836 1942