

FILED DEC 9 1942

Registration District No. 268

Primary Registration District No. 5905

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

1. PLACE OF DEATH:

(a) County Missouri  
(b) City or town General Retail Fair  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1 Godair  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Missouri  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4 miles southwest protagville  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Lissie Swinger

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

4. Sex F 5. Color or race C 6. (a) Single, widowed, married 2 divorced widowed

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

7. Birth date of deceased (Month) 8 (Day) 14 (Year) 1927

8. AGE: Years 65 Months 2 Days 17 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Charlestown S. Carolina (City, town, or county) (State or foreign country)

10. Usual occupation housekeeper

11. Industry or business home

MOTHER FATHER { 12. Name Jahn Carter

13. Birthplace Charlestown S. Carolina (City, town, or county) (State or foreign country)

14. Maiden name Ada Jones

16. Birthplace Charlestown S. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Herbert Swinger

(b) Address protagville MO

17. (a) Burial (b) Date thereof 11-7-42 (Month) (Day) (Year)

(c) Place: burial or cremation Woodell Mt

18. (a) Signature of funeral director W. Smith

(b) Address Hayth

19. (a) 11 7 42 (b) J. H. Hays (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31 year 1942 hour 2 minute 30 A.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 meningitis complicated with a dropsey over a long period of time no medical attention  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Duration

PHYSICIAN

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

Of autopsy \_\_\_\_\_

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. H. Hays (M. D. or other)

Address Hayth Date signed Oct 31 1942

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

78  
00

12-42-13

**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 *J. Brown*  
Licensed Embalmer No. 3789  
P. O. Address *Hayward*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37745-

Registration District No. 268

Primary Registration District No. 5905

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

1. PLACE OF DEATH:

(a) County Pemiscot  
(b) City or town Rural  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

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

20. DATE OF DEATH: Month October year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; \_\_\_\_\_ 19\_\_\_\_; \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death anemia complicated with dropsy over a long period of time

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased: Aug 14 (Month) (Day) (Year)

8. AGE: Years 65 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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 \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

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

Duration \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

