

FILED JUL 31 1943  
Registration District No. **9**

Primary Registration District No. **4097**

Registrar's No. **142**

1. PLACE OF DEATH:

(a) County **Cass**  
(b) City or town **Harrisonville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Harrisonville Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5 weeks**  
(Specify whether  
In this community **26 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Cass**  
(c) City or town **Harrisonville Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **800 West Wall**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? **0** years.

3. (a) PRINT FULL NAME **Laura May Swathney**

3. (b) If veteran,  name war **Laura May Swathney**  
3. (c) Social Security No.

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

6. (b) Name of husband or wife **Joseph H. Swathney** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **July 24 - 1881**  
(Month) (Day) (Year)

8. AGE: Years **61** Months **11** Days **25** If less than one day hr. min.

9. Birthplace **Kansas**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Home wife**

11. Industry or business **L**

12. Name **Daniel Blankenship**

18. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)

14. Maiden name **Blarissa Bogg**

15. Birthplace **Ill.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph H. Swathney**

(b) Address **Harrisonville Mo.**

17. (a) **Burial** (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director **RUNNENBURGER'S**

(b) Address **HARRISONVILLE MO**

19. (a) **July 20, 1943** (b) **Margaret Valle**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **19** year **1943** hour **12** minutes **30 a.** M.

21. I hereby certify that I attended the deceased from **July 19** 19**43** to **July 19** 19**43**  
that I last saw him alive on **July 19** and that death occurred on the date and hour stated above.

Immediate cause of death **Ruptured aneurysm of the aorta**

Due to **Internal Hypertension**

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) (b) Means of injury

23. Signature **David Stone** (M. D. or other)

Address **Harrisonville Mo** Date signed **7/20 43**

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

SEP 4 1945

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 Ernest Rannenburg  
Licensed Embalmer No. 3368  
P. O. Address Harrisonville 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.

Registration District No. 59 Primary Registration District No. 4097

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

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Harrisonville  
(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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Laura May Guathmey

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 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)

8. AGE: Years Months Days (Unless than one day) min. 61 11 24

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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 July Year 1943 Hour 11 Minute 19 M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death Arteriosclerosis of aorta

Due to lesions of myocardium  
Due to arterial hypertension

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 David Stone (M. D. or other)

Address Harrisonville Mo Date signed 8/2-43

**SUPPLEMENTARY**  
Duration 10 to 15 M  
PHYSICIAN 309  
Underline the cause to which death should be charged statistically.

S-24647