

27776
33776
93976

FILED SEP 11 1943

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **0**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Mo. 19 Days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1119 Lincoln**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Ronald Lee Swoboda**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **NO**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 8 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
*** 1 16** hr. min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Baby**

11. Industry or business _____

MOTHER FATHER
12. Name **Ralph John Swoboda**
13. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Verna Moore**
15. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ralph John Swaboda**
(b) Address **1119 Lincoln, St. Joseph, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **August 26**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mount Mora Cemetery**

18. (a) Signature of funeral director **Norman W. Sidenfaden**

(b) Address **1802 Union, St. Joseph, Mo.**

19. (a) **8/26/43** (Date received local registrar) (b) **Joe Heagy** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **24**
year **1943** hour **11** minute **30 P.M.**
21. I hereby certify that I attended the deceased from **8/25/43**
to **8/25/43**, 19____ to _____, 19____;
that I last saw him/her on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Septic dration** **2 days**
Due to **Infectious Mononucleosis** **11**

Due to _____
Other conditions **Hypertension** **10 hrs**
(Include pregnancy within 3 months of death)

Major findings: Of operations **119a**
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 **Joe Heagy** (M. D. or other) **8/25/43**
Address **St. Joseph Mo.** Date signed **8/25/43**

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

1233

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 John H. Hurley
Licensed Embalmer No. 4050
P. O. Address St. Joseph, 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, fact should be so stated above.