

FILED NOV 19 1943
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 days**
(Specify whether
In this community **50 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2843 Troost**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Annie L. Swomley**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **N 8**

4. Sex **Female** 5. Color or race **Wht.** 6. (a) Single, widowed, married, divorced, **widow**
6. (b) Name of husband or wife **unk** 6. (c) Age of husband or wife if alive **unk** years
7. Birth date of deceased **Apr. 28 1864**
(Month) (Day) (Year)

8. AGE: Years **79** Months **7** Days **8** If less than one day **hr. min.**

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

10. Usual occupation **at home**

MOTHER FATHER
11. Industry or business
12. Name **Galie Stopp**
13. Birthplace **Indy** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Feland**
15. Birthplace **Indy** (City, town, or county) (State or foreign country)

16. (a) Informant **Helen Lawson**
(b) Address **Shakland Mo**

17. (a) (Burial, cremation, or removal) (b) Date thereof **10/29/43**
(Month) (Day) (Year)
(c) Place: burial or cremation **Shrewsbury Mo**

18. (a) Signature of funeral director **Thine McClure**

(b) Address **40000 0th Mo**
19. (a) **10-30-43** (b) **N. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **29th**
year **1943** hour **7** minute **21 P.** M.

21. I hereby certify that I attended the deceased from **October 21, 1943 to October 29, 1943**
that I last saw her alive on **October 29th, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia** Duration
Arteriosclerotic gangrene of left foot

Due to **9812**

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) Means of injury
23. Signature **Anney R. Hora** (M. D. or other)
Med. Dir. Gen'l Hosp. Address **10-30-43** Date signed

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.....

A. J. Allen

Licensed Embalmer No. 1415

P. O. Address 14 E 100

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.