No. 2
2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 23 1944

Registration District No. 150

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5572

State File No. 7375

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural (Prairie Twp)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County E & Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hours (Specify whether years, months or days)

In this community 29 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Fairmount Station R.F.D. 6 (If outside city or town limits, write "RURAL")

(d) Street No. 9812 Morrell (If rural, give location)

(e) Citizen of foreign country? ? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Andrew Swanson

3. (b) If veteran, name war None

3. (c) Social Security No. 495-09-5556

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cassa Swanson

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased May 19 1870 (Month) (Day) (Year)

8. AGE: Years 63 Months 7 Days 22 If less than one day hr. min.

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

10. Usual occupation Stationary Fireman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown Sweden (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown Sweden (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Cassa Swanson Wife
(b) Address 9812 Morrell K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-44 (Month) (Day) (Year)

(c) Place: burial or cremation Mount Washington

18. (a) Signature of funeral director George A Gibson

(b) Address Quality cemetery Mo

19. (a) Jan. 13, 1944 (Date received local registrar) (b) F.M. Schuck by Effie Schuck (Registrar's signature)

1162

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1944 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov 13, 1943, to Jan 11, 1944, that I last saw him alive on Jan 11, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Anemia	
Due to Cancer	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature F W Tuttle (M. D. or other) MD

Address Blue Springs Mo. Date signed 1/10/44

(Licensed Embalmer's Statement on Reverse Side)

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 Floyd L. Carson

Licensed Embalmer No. 4199

P. O. Address Independence, Ia

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 3

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Prairie Prairie Twp.
(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

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 Andrew Swanson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 May (Month) 19 (Day) 18 (Year)

8. AGE: Years 63 Months 7 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Anemia

Due to Cancer of liver and metastasis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operation
Of autopsy

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)
(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 J. W. Tuttle (M. D. or other) M.D.
Address Blue Springs Mo Date signed 3/4/44

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION RECEIVED

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