

No. 2  
5-42  
17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUL 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21396  
9/28

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Calay  
(b) City or town Excelsior Springs  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community about 25 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Calay 24  
(c) City or town Excelsior Springs 1  
(d) Street No. 314 Wayne 1  
(If outside city or town limits, write "RURAL")  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Warren Winslow Swearingen

3. (b) If veteran, name war no 3. (c) Social Security No. 491-01-8405

4. Sex male 5. Color or race w  
6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife Ruby Pauline  
6. (c) Age of husband or wife if alive 41 years  
7. Birth date of deceased Mar 16 1902  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
42 | 3 | 0 | hr. min.

9. Birthplace Os Halls Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation foreman

11. Industry or business Mo Power Light Co

12. Name John A Swearingen

13. Birthplace Clinton Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Ada Evans

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

16. (a) Informant Jella Swearingen  
(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 6-21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Clyde Richard  
(b) Address Excelsior Springs Mo

19. (a) 6-21-44 (b) Mr. Stadel Redman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16  
year 1944 hour 7 minute 30 P M.

21. I hereby certify that I attended the deceased from June 16, 1944, to June 16, 1944  
that I last saw him alive on June 16, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death acute dilated heart

Due to Pt came home very worn from work - over eat out front

Due to apoplexy

Other conditions 9504  
(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? SR Milwaukee (Specify type of place) (e) Means of injury MO

23. Signature SR Milwaukee (M. D. or other) MD  
Address Excelsior Springs Mo Date signed 6/21/44

Duration 1 1/2 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed: 7-6-47

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: *Paul Rapp*  
Licensed Embalmer No. 3458  
P. O. Address: *Ch. Spgs. 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.