

FILED NOV 10 1944

Registration District No. 25

Primary Registration District No. 7010

Registrar's No. 350

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)
In this community 3 months 29 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Cape Girardeau
(If outside city or town limits, write "RURAL")
(d) Street No. 302 South Spanish Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Buell Swinford Jr.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male race White 5. Color or divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 22, 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 3 29 hr. min.

9. Birthplace Cape Girardeau Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Buell Swinford
13. Birthplace Cape Girardeau Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Gertie Bass
15. Birthplace Advance Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gertie Swinford
(b) Address Cape Girardeau, Missouri

17. (a) Burial (b) Date thereof 10-22-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairmont Cemetery

18. (a) Signature of funeral director L.L. Haman

(b) Address Cape Girardeau Missouri

19. (a) 10-22-44 (b) F.R. Helms
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21st
year 1944 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from October 20,
1944, to October 21, 1944;
that I last saw him alive on October 20, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Colitis, chronic Duration 14

Due to _____

Due to 119a²

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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 [Signature] (M.D. or other) [Signature]

Address 302 N. 3rd St. Cape Girardeau, Mo. Date signed 10/21/44

1014

District Health Officer No. 4
District File Number 1144-4554
Date Filed 11-8-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.