

Registration District No. \_\_\_\_\_

Primary Registration District No. 3072

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Baker's Clinic  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 days  
(Specify whether years, months or days)  
In this community 20 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Towa (b) County 949  
(c) City or town Garden  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? 2 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT Elmer M. Swanson  
FULL NAME

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. unk

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

8. AGE: Years 58 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation unk

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name unk  
13. Birthplace unk (City, town, or county) (State or foreign country) 9  
14. Maiden name unk  
15. Birthplace unk (City, town, or county) (State or foreign country) 9

16. (a) Informant Hospital Records

(b) Address Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 4-28-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garden Towa

18. (a) Signature of funeral director Albader

(b) Address Excelsior Springs, Mo.

19. (a) 4-28-45 (Date received local registrar) M. Alderman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4-28 day \_\_\_\_\_  
year 45 hour 5:45 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from Apr 9th  
1945 to 4-28 1945;

that I last saw him alive on 4-28 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of lower bowel

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Peritonitis  
(Include pregnancy within 3 months of death)

Major findings: Of operations 7/6/45

Of autopsy unk

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 Mason C. Alderman M. D. or other \_\_\_\_\_

Address Excelsior Springs, Mo. Date signed 4-28-45

Duration

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 5/2/45

JUN 12 1945

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 Claude F. Richart

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs, 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.