

FILED APR 19 1945

Registration District No. 2

Primary Registration District No. 3074

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(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 _____)
In this community 35 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Alb. Swinford

3. (b) If veteran, name war None 5. (c) Social Security No. None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 9 divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased January 27 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 11 27 hr. min.

9. Birthplace Kentucky
(City, town, or county) (State or foreign country) 1

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name John Swinford
13. Birthplace Del.
(City, town, or county) (State or foreign country)
14. Maiden name Widow
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Raymond Swinford

(b) Address 726 N. Wildwood - Kansas, Ill.

17. (a) Perkins, Custary (b) Date thereof 1 26 1945
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Perkins, Custary

18. (a) Signature of funeral director W. L. Turner

(b) Address Sikeston, Mo.

19. (a) 4/7/45 (b) L. A. Largent
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24
year 1945 hour 2 minute 05 A.M.

21. I hereby certify that I attended the deceased from Jan 16 to Jan 16, 1945;
that I last saw him alive on Jan 16, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

St. Bernard Phenomena

Due to _____

Due to _____

Other conditions (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? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. P. Yaker (M. D. or other) _____

Address Sikeston Date signed 4/2/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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RECEIVED

District Health Office No. 2,

District File Number 445-600

Date Filed 4/14/45

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: Raymond Crews

Licensed Embalmer No. 3467

P. O. Address. Sibleston, 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.