

FILED JUN 13 1945

Registration District No. 200

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5725

State File No. 17477

Registrar's No. 67

1. PLACE OF DEATH:

(a) County macon
(b) City or town macon Waldron June
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Infirmary 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County macon 61
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 5 miles West of New Cambria
(If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THOMAS SHERMAN SWANK

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 10 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 10 21 _____ hr. _____ min.

9. Birthplace New Cambria mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____
12. Name Jonathan Swank
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Susan Laney
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Lurgan
(b) Address New Cambria Mo.

17. (a) Burial (b) Date thereof June 3 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laney Cemetery

18. (c) Signature of funeral director H. J. Hillebrand
(b) Address New Cambria Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
year 1945 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 13
19 45 to _____, 19 _____

that I last saw him alive on May 27, 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis with deceleration

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 Lois Miller (M. D. or other) _____
Address Marion Mo Date signed 6/2/45

Duration ?
not

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

RECEIVED

District Health Officer No. 10

District File Number 6-45-95

Date Filed 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 H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambridge, Mass.

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.

Registration District No. *200*

Primary Registration District No. *5725*

1. PLACE OF DEATH:

(a) County *Macou*
(b) City or town *Macou Aerial Station*
(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 _____ years, months or days

3. (a) PRINT FULL NAME *Thomas S Swank*

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

4. Sex *in* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *s*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *July 10 1966*
(Month) (Day) (Year)

8. AGE: Years *75* Months *10* Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) *mo*

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (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) (Registrar's signature) *Jana B. Hunkeler*

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* Day _____ Year *1945* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

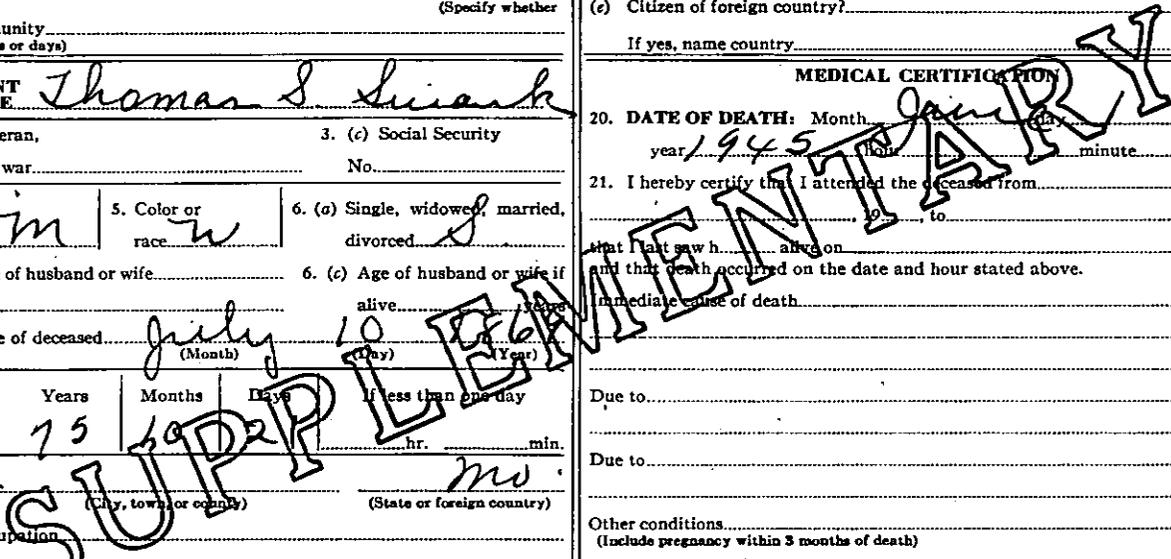
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____



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

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3880

17477