S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 8 1945

State File No. 30607

Registration District No. 128 | Primary Registration District No. 2000 | Registrar's No. 770

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: SPRINGFIELD (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. JOHNS HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: ARK. (b) County: BOONE 979
(c) City or town: HARRISON (If outside city or town limits, write "RURAL") 3
(d) Street No.: 705 COLLEGE (If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No) 2
If yes, name country: ✓

3. (a) PRINT FULL NAME: MYRTLE MAY SWAFFORD
3. (b) If veteran, name war: NONE
3. (c) Social Security No.: NONE
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOW
6. (b) Name of husband or wife: UNK.
6. (c) Age of husband or wife if alive: DEC. years
7. Birth date of deceased: Sept. (Month) 3, (Day) 1896 (Year)

8. AGE: Years 49 | Months 0 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace: Bergman (City, town, or county) Ark. (State or foreign country) 1
10. Usual occupation: House wife
11. Industry or business: At Home
FATHER
12. Name: Will O. Price
13. Birthplace: UNK (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name: Ella Roberts
15. Birthplace: Little Rock (City, town, or county) Ark. (State or foreign country) 1
16. (a) Informant: Lota Weston
(b) Address: 1043 Thelma Ave. Springfield Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Sep 28-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Bergman, Ark.
18. (a) Signature of funeral director: Christeson Funeral Home
(b) Address: Harrison Arkansas
19. (a) 9-28-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 27 year 1945 hour 4 minute 35 P. M.

21. I hereby certify that I attended the deceased from Feb 2, 1937 to Sept 27, 1945 that I last saw her alive on Sept 27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Uraemia
Due to: Pyonephrosis
Due to: 1937 left nephrectomy 1944 Stones removed rt. ureter.
Other conditions (Include pregnancy within 3 months of death)
Major findings: Fatal Dilated Kidney
Operations: found, rt. gut along
Date: Jain united Sept 1945
Of autopsy: no.

Duration

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

23. Signature: Walter Hewell M. D. or other
Address: Springfield Mo. Date signed: 9-28-45

(Licensed Embalmer's Statement on Reverse Side)

NOV 28 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.....

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.