. No. 2
I—5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 84336

FILED NOV 8 1945

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 262

1. PLACE OF DEATH:
(a) County PETTIS
(b) City or town SEDALIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BOTHWELL HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 MONTHS (Specify whether years, months or days)
In this community LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County PETTIS 89
(c) City or town SEDALIA 6
(If outside city or town limits, write "RURAL")
(d) Street No. 606 S. OSAGE 4
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JOHN HENRY SWOPE
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE 0
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife EDITH
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 8 (Month) – 8 (Day) – 1869 (Year)
8. AGE: Years 76 Months 1 Days 25 If less than one day hr. min.
9. Birthplace PETTIS Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation RETIRED
11. Industry or business FARMING
MOTHER FATHER
12. Name JESSIE SWOPE 9
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name MARY ALEXANDER
15. Birthplace UNKNOWN (City, town, or county) 01 (State or foreign country)
16. (a) Informant C. W. SWOPE 1
(b) Address SEDALIA, Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-4-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. HERRIMAN CEMETERY
18. (a) Signature of funeral director Gillespie
(b) Address SEDALIA, Mo
19. (a) 10/4/45 (Date received by local registrar) (b) A. G. Campbell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 3RD year 1945 hour 1 minute 45 A.M.
21. I hereby certify that I attended the deceased from May 2, 1945 to OCT 3, 1945 and that I last saw him alive on OCT 2, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chr. myocarditis and Bright's disease	
Due to: arterio sclerosis & hypertension	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations:
Of autopsy:

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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
Signature J. W. Boggess M.D.
Address Sedalia, Mo. Date 10/4/45

1496 (Licensed Embalmer's Statement on Reverse Side)

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

District Health Officer No. 8,

District File Number

Date Filed 11-7-44

NOV 9 19

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 L. E. Boulchin

Licensed Embalmer No. 3867

P. O. Address Sedalia 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.

S. No. 2B
M—5-43
Form I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 262

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(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)

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

3. (a) PRINT FULL NAME John H. Swope

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 8 (Day) 1868 (Year)

8. AGE: Years 76 Months 1 Days 25 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (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) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Chronic interstitial nephritis	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

34336