

No. 2
-8-43
-17-39
X37823

FILED JAN 9 1946

State File No. _____
Registrar's No. 20

Registration District No. _____ Primary Registration District No. 5562

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Creedia - Rural No. 04
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: The Home for aged Baptists 5 mi
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days
(Specify whether years, months or days)

In this community 14 days

3. (a) PRINT FULL NAME John Lawrence Swearingin

3. (b) If veteran, name was none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary Elizabeth Pruitt

6. (c) Age of husband or wife if alive 14 years

7. Birth date of deceased Dec. 14, 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	-	6	hr. min.

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

10. Usual occupation Baptist Minister

11. Industry or business Preaching Gospel

12. Name Noah Swearingin

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

14. Maiden name Mary Elizabeth Craig

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

16. (a) Informant Jos. H. Bursney

(b) Address Fronton, Mo.

17. (a) Reburied (b) Date thereof 12-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woberley, Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Fronton, Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron 47

(c) City or town Creedia - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 1 1/2 mile east on Highway 70
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
year 1945 hour 6:45 minute A.M.

21. I hereby certify that I attended the deceased from Dec. 18th
1945, to Dec. 20th 1945

that I last saw him alive on Dec. 18th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death acute Bilateral Bronchial
Pneumonia --- 12/18/45

Due to Influenza --- 12/10/45

Due to _____

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

Major findings:
Of operations _____

Of autopsy 33K

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) _____ (c) Means of injury _____

23. Signature R. E. Harland (M. D. or other) M.D.
Address Fronton, Mo. Date signed 12/20/45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 146-1528
Date Filed 1-8-46

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 Rachel White
Licensed Embalmer No. 3012
P. O. Address Amston, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 20

Registration District No. 144 Primary Registration District No. 5562

1. PLACE OF DEATH:
(a) County Iron
(b) City or town Russell
(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 Lawrence Swearingen
(b) If veteran, name war _____ (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 Dec 14, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 12-25-75 (b) Mrs Avis Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY

41388