

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 798

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days) 6 days

In this community 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Woodsbury

(c) City or town Woodsbury
(If outside city or town limits, write "RURAL")

(d) Street No. - (If rural, give location) D

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

If yes, name country _____

3. (a) PRINT FULL NAME SARA SWANEY
Sara Swaney

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid. 2

6. (b) Name of husband or wife Napoleon

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

7. Birth date of deceased April 10 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 5
If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER

12. Name John Frymire

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

14. Maiden name Unknown " Unknown

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

16. (a) Informant Co. Church

(b) Address Woodsbury

17. (a) Burial (b) Date thereof July 17, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Clearmont Mo.

18. (a) Signature of funeral director Price Funeral Home

(b) Address Marionville Mo.

19. (a) July 16, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1946 hour _____ minute 4 M.

21. I hereby certify that I attended the deceased from July 4
to July 15, 1946.
that I last saw ex alive on July 15, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary 4/3 4/17

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)

(a) Means of injury _____

23. Signature [Signature] (M. D. or other) MD

Address State Hosp. St. Joseph Date signed 7/17/46

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

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

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.....

John W. Price

Licensed Embalmer No.....

4281

P. O. Address.....

Maryville 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.