

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

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43  
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36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29795

Registration District No. 386 Primary Registration District No. 4082 State File No. \_\_\_\_\_ Registrar's No. 11

1. PLACE OF DEATH:  
(a) County CARROLL  
(b) City or town Bogard  
(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 19 years. (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME George Washington Swope  
3. (b) If veteran, name war No 3. (c) Social Security No. No.

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Carrie Ethel Swope 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased April 27 1863  
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Jacob Swope  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Rud.  
15. Birthplace Don't Know 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs William Terrill  
(b) Address Bogard, Mo.

17. (a) Burial (b) Date thereof Sept 8-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Avalon

18. (a) Signature of funeral director E. A. Dickerson  
(b) Address Bogard Mo.

19. (a) Sept 8-1946 (b) Eunice Street  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Carroll 17  
(c) City or town Bogard 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6  
year 1946 hour 2:30 minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from Sept 2  
1946 to Sept 14 1946  
that I last saw h. live on Sept 14 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Duration 4 days

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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external cause, 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) Means of injury 2  
23. Signature G. G. Alcorn D.O. (M. D. or other)  
Address Bogard, Mo Date signed 9/5/46

48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8

District File Number \_\_\_\_\_

Date Filed 9-21-46

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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.....

*E. A. Dickerson*

Licensed Embalmer No. 2534

P. O. Address Bogard, 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. \

Registration District No. 386

Primary Registration District No. 4082

1. PLACE OF DEATH:

(a) County Cassell  
(b) City or town Bogard  
(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 George W. 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 \_\_\_\_\_

7. Birth date of deceased April 27 1861  
(Month) (Day) (Year)

8. AGE: Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Sept 2 to Sept 6, 1946; that I last saw him alive on Sept 5, 1946, and that death occurred on the date and hour stated above.  
Immediate cause of death premia

Due to Cardiac Decompensation 10 yr.

Due to Coronary Sclerosis 4 da

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
95C

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? \_\_\_\_\_

23. Signature H. S. Alcorn (M. D. or other) \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
Address Bogard, Mo Date signed 10/4/46

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

28631

SUPPLEMENTARY

29795