

7. S. No. 2  
00M 2-13  
ev. 5-11-39  
X35897

Wilson

32447

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 23 1946

Registration District No. 387

Primary Registration District No. 6179

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Jackson Twp  
(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.  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County Sullivan  
(c) City or town Milan Rural  
(d) Street No.  
(e) Citizen of foreign country? No  
If yes, name country.

3. (a) PRINT FULL NAME James William Swearingen

3. (b) If veteran, name war: W  
3. (c) Social Security No.

4. Sex M O 5. Color or race W  
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased July 29 1908  
(Month) (Day) (Year)

8. AGE: Years 38 Months 1 Days 10  
If less than one day hr. min.

9. Birthplace Sullivan Co. Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name T. J. Swearingen  
13. Birthplace Sullivan Co. Ill  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Franklin

15. Birthplace Sullivan Co. Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant T. J. Swearingen

(b) Address Milan Ill

17. (a) Burial (b) Date thereof 9-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director Schaefer  
(b) Address Milan Ill

19. (a) Sept 19-1946 (b) Mrs. H. B. Harris  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9  
year 1946 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from June 8  
1946, to Sept 9 1946  
that I last saw him alive on Aug 11 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Probable carcinoma not known at present

Due to

Due to

Other conditions Chronic diarrhea  
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 55E  
N.M.I. ADDITIONAL SUPPLEMENTARY INFORMATION

22. If death was due to external causes, find 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) (e) Means of injury

23. Signature J. S. Montgomery (M. D. or other)  
Address Milan Ill Date signed

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

220 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
DISTRICT REGISTRY OF DEPT. OF HEALTH  
District No. 100  
Date Filed  
2-46-1723  
SEP-23-1946

---

---

**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.**