

No. 2
-12-45
5-17-39
1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5833**
Registrar's No. **42**

FILED MAR 12 1947
Registration District No. **294**

Primary Registration District No. **3056**

1. PLACE OF DEATH:
(a) County: **Randolph**
(b) City or town: **Moberly**
(c) Name of hospital or institution:
600 Cleveland Ave
(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: **Susie M. Swetnam**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex: **Female** 5. Color or race: **White**
6. (a) Single, widowed, married, divorced: **Widow**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Oct 28th 1874**
(Month) (Day) (Year)

8. AGE: Years **72** Months **3** Days **14**
If less than one day _____ hr. _____ min.

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

10. Usual occupation: **At home**

11. Industry or business _____

MOTHER FATHER { 12. Name: **Matthew H Neal**
13. Birthplace: _____
(City, town, or county) (State or foreign country) **Va**
14. Maiden name: **Mary A Irons**
15. Birthplace: _____
(City, town, or county) (State or foreign country) **Mo**

16. (a) Informant: **Miss Salie Neal**
(b) Address: **Moberly Mo**
17. (a) **Removal** (b) Date thereof: **Feb 13-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **Chicago, Ill**

18. (a) Signature of funeral director: **Mahon and Son**
(b) Address: **Moberly Mo**
19. (a) **Feb 15-47** (b) **Leah Sheppard Crow**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: **Illinois** (b) County: **Cook** **999**
(c) City or town: **Chicago** **11**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No) **2**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **12th**
year **1947** hour _____ minute **25 P.M.**
21. I hereby certify that I attended the deceased from **Feb 11**, 19**47** to **Feb 12**, 19**47**
that I last saw **her** alive on **Feb 11**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Complete Heart Block**
Hypertensive Heart
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: **930**
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) (Means of injury) **0**
23. Signature: **[Signature]** (M.D. or other) _____
Address: **Moberly Mo** Date signed **2-13-47**

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

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MAR 20 1947

MAR 20 1947

RECEIVED

District Health Officer No. 10
District File Number 347-446

MAR 11 1947

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..... *Frank D. DeWitt*

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.