

**FILED APR 14 1947**

Registration District No. **184**

Primary Registration District No. **3038**

Registrar's No. **17**

**1. PLACE OF DEATH:**  
 (a) County Linn  
 (b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: McJarnays  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days)

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

**3. (a) PRINT FULL NAME** Marion Vincent Swihart  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month April day 1st  
 year 1947 hour 9 minute P. M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Roweina Swihart  
 6. (c) Age of husband or wife if alive 37 years  
 7. Birth date of deceased May 30 1894  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 28 1946 to April 1 1947  
 that I last saw him alive on April 1 1947  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>11</u>	<u>1</u>	hr. _____ min. _____

Immediate cause of death Cancer of Gall bladder and liver  
 Duration 2 years

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

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

10. Usual occupation Farming

Other conditions None  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
**MOTHER FATHER**  
 12. Name Warren Swihart  
 13. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
 14. Maiden name Amy E. Cleveland  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

Major findings: None  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Marion Swihart  
 (b) Address Bedford, Missouri

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 4-3-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Wheeling Cemetery

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury 2)

18. (a) Signature of funeral director Norman Funeral Home  
 (b) Address Chillicothe, Missouri  
 19. (a) 4-3-47 (b) Walter Brown  
(Date received local registrar) (Registrar's signature)

23. Signature Dr. Alvin Allett (M. D. or other) D.O.  
 Address Hale, Mo Date signed 4-3-47

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

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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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, Elton J. Norman

Licensed Embalmer No..... 4036

P. O. Address..... Chillicothe, 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.**