

FILED OCT 20 1947

Registration District No. **133**

Primary Registration District No. **3022**

Registrar's No. **78**

1. PLACE OF DEATH:

(a) County **Harrison**  
 (b) City or town **Bethany**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Bethany Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: **Three weeks**  
(Specify whether in hospital or institution)  
 In this community **Three weeks**  
(years, months or days)

3. (a) PRINT FULL NAME **Carrie Beatrice Swartz**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color of race **W** 6. (a) Single, widowed, married, divorced **W 2**  
 6. (b) Name of husband or wife **Harry Swartz Deceased** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Feb 25 1894**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>53</b>	<b>6</b>	<b>10</b>	hr. _____ min. _____

9. Birthplace **Harrison County MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House Keeper**

MOTHER FATHER } 11. Industry or business \_\_\_\_\_

12. Name **Charles A. Madden**

13. Birthplace **Harrison County MO**  
(City, town, or county) (State or foreign country)

14. Maiden name **Lena Burger**

15. Birthplace **Harrison County MO**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Shelly Ross**

(b) Address **New Hampton**

17. (a) **Buried** (b) Date thereof **Sept 7 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Foster**

18. (a) Signature of funeral director **W. H. Noble**

(b) Address **New Hampton MO**

19. (a) **Oct 1-47** (b) **Zola Burris**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Harrison 41**  
 (c) City or town **New Hampton** **0**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **Arch Street** **0**  
(If rural, give location)  
 (e) Citizen of foreign country? **No** **0** (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **5** year **1947** hour **5** minute **10 A** M.

21. I hereby certify that I attended the deceased from **June 18,** 1947, to **Sept 5,** 1947, that I last saw her alive on **Sept 5,** 1947, and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis** Duration **4 days**

Due to **Perforation of bowel** **4 days**

Due to **Carcinoma of Colon** **6 mo.**

Other conditions **(Carcinoma of Colon)**  
(Include pregnancy within 3 months of death)

Major findings: Of operation **Carcinoma of descending colon**  
 Of autopsy **H&E**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature **W. F. Boyler** (M. D. or other) **MD**  
 Address **Bethany MO** Date signed **9/7/47**

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

OCT 8 1953

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed W H Noble

Licensed Embalmer No. 2904

P. O. Address New Hampton

**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.