

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 9 1947

Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 180

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Jesse Chinn Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jasper
(c) City or town Webb City
(If outside city or town limits, write "RURAL")
(d) Street No. 901 N. TOM
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME AGNES SWINGLE

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased No data
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 68 hr. min.

9. Birthplace No data (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business.....

12. Name No data

13. Birthplace No data (City, town, or county) (State or foreign country)

14. Maiden name Kate Holston

15. Birthplace No data (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jim Hubbard

(b) Address Webb City MO

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-5-47 (Month) (Day) (Year)

(c) Place: burial or cremation Galena Home

18. (a) Signature of general director Galena Home

(b) Address Galena Home

19. (a) Dec 7 1947 (Date recorded by registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2 year 1947 hour 5 minute 40 A.M.
21. I hereby certify that I attended the deceased from Nov 24 1947 to Dec 1 1947 that I last saw him alive on Dec 1 and that death occurred on the date and hour stated above.

Immediate cause of death Transition - lack of food + care

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death).....

Major findings: 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?..... Means of injury.....
Signature R. M. Stinson (M. D. number) 5
Address Webb City Mo Date signed 12/3/47

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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 _____

Steve Parker

Licensed Embalmer No. 2548

P. O. Address Joplin, 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.