

Registration District No. 114

Primary Registration District No. 3035

1. PLACE OF DEATH:

(a) County Way

(b) City or town Wayville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 1822 Poplar St  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None  
(Specify whether years, months or days)

In this community 11 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Way

(c) City or town Wayville  
(If outside city or town limits, write "RURAL")

(d) Street No. 1822 Poplar  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MATTHEW G. SWINNEY

3. (b) If veteran, name war WORLD WAR I

3. (c) Social Security No. 500-10-778

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4 year 1948 hour 7 minute 30 A M.

21. I hereby certify that I attended the deceased from 20 July 46 to \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h. IM alive on 31 Dec, 1947 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Helen Swinney

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Apr 7 1897  
(Month) (Day) (Year)

Immediate cause of death hypertensive cardio vascular disease with congestive failure

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

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

8. AGE: Years 50 Months 8 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions 9/27  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Wayton Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

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? \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name James T Swinney

13. Birthplace Carroll Green Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Stella Barnes

15. Birthplace Mo  
(City, town, or county) (State or foreign country)

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

Signature Joel W. Wood (M. D. or other) \_\_\_\_\_  
Address Wayton Mo Date signed 6 Jan 48

16. (a) Informant Helen Swinney

(b) Address Wayton Mo

17. (a) Burial (b) Date thereof 1/6/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo

18. (a) Signature of funeral director James Archer

(b) Address Wayton Mo

19. (a) 7 Jan 48 (b) Marshall Mo  
(Date received local registrar) (Registrar's signature)

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

57  
3  
2

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-17-48

for Joe Ward

FEB 9

JAN 21 1948

FEB 2 - 1948

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

Harold G. Smith

Registered Apprentice No. 23

working under my personal supervision.

Signed

John S. Korberg

Licensed Embalmer No. 4448

P. O. Address Liberty 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.