S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7685

FILED APR 8 1948

Registration District No. .....

Primary Registration District No. 3000

Registrar's No. 98

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Grim-Smith Memorial Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair 1
(c) City or town Novinger 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country .....

3. (a) PRINT FULL NAME Frank M. Swanson
3. (b) If veteran, name war .....
3. (c) Social Security No. None
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or wife Grace Frankford
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Sept. (Month) 6 (Day) 1875 (Year)

8. AGE: Years 72 Months 6 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace Quincy (City, town, or county) Illinois (State or foreign country) 1
10. Usual occupation Retired Businessman & Miner
11. Industry or business .....
FATHER
12. Name Andrew Swanson
13. Birthplace Smolen (City, town, or county) Sweden (State or foreign country) 4
MOTHER
14. Maiden name Inga Maree Johnson
15. Birthplace Smolen (City, town, or county) Sweden (State or foreign country) 4
16. (a) Informant Grace Swanson
(b) Address Novinger, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/48 (Month) (Day) (Year)
(c) Place: burial or cremation Novinger Cemetery
18. (a) Signature of funeral director Dee Riley Funeral Home
(b) Address Kirksville, Missouri.
19. (a) 4-3-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1948 hour 3:30 minute P. M.
21. I hereby certify that I attended the deceased from Mar 15, 19..., to Mar 22, 1948
that I last saw her alive on Mar 22, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Parotitis, Acute	3 days
Due to Gastro-enteritis, Acute	1 wk
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

44C

PHYSICIAN
Underline the cause of 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 [signature] (M. D. or other) MD
Address Kirksville, Missouri Date signed 3/22/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-48-628
APR -7 1948
Date Filed

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 Jack L. Dooley Registered Apprentice No. 222 working under my personal supervision.

Signed Dee Riley

Licensed Embalmer No. 4181

P. O. Address Kirksville 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.