

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution: State Hospital # 32
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution 3 yrs. 3 mos. 25 d.
In this community 3 yrs - 3 mos. 28 days.
years, months or days

3. (a) PRINT FULL NAME Robert Swift.

3. (b) If veteran, name war. DK

3. (c) Social Security No. DK

4. Sex MO

5. Color or race W

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

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased 4 - 11 - 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
82	1	20	hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name Willis Harlin Swift

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

14. Maiden name Elizabeth Ricketts

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

16. (a) Informant Records

(b) Address State Hospital # 3

17. (a) Buried (b) Date thereof 5-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo Mo.

18. (a) Signature of funeral director Montgomery Vaughan

(b) Address Buffalo Mo.

19. (a) 5-17-48 (b) Kathryn Vance
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 30

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

(d) Street No. Rural
(If rural, give location)

(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 5 day 17
year 1948 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from 6-1-46 to 5-17-48
that I last saw him alive on 5-16-48
and that death occurred on the date and hour stated above.

Immediate cause of death:

1. Cerebral Arteriosclerosis 3 yrs +

2. Senile Dementia 10 yrs +

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 97

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? _____ (Specify type of place) _____
Means of injury _____

23. Signature J. Bunch (M. D. or other) _____
Address State Hospital # 3 Date signed 5-17-48

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

RECEIVED

District Health Officer- No. 7,

District File Number 4-48-551

Date Filed 5-21-48

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 Clyde Montgomery
Licensed Embalmer No. 3592
P. O. Address Buffalo, 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, above space should be left blank.