

FILED AUG 16 1948

Registration District No. **143**Primary Registration District No. **5558**Registrar's No. **68**

## 1. PLACE OF DEATH:

(a) County Howell  
 (b) City or town Dry Creek Twp.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Rural  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 61 years  
 years, months or days)

3. (a) PRINT FULL NAME James W. Swearingen

3. (b) If veteran, name war None  
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Bessie 6. (c) Age of husband or wife if  
olfarth Swearingen alive 59 years  
 7. Birth date of deceased Jan. 11, 1884  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>5</u>	<u>27</u>	_____ hr. _____ min.

9. Birthplace Salem Arkansas  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

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

MOTHER FATHER { 12. Name Henry W. Swearingen 7  
 { 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 { 14. Maiden name Rebecca Smith 9  
 { 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Swearingen(b) Address Rt. 2, Pomona, Missouri17. (a) Burial (b) Date thereof 7/11/48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mackey Cemetery

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address Willow Springs, Missouri19. (a) 7/26/48 (b) Marshall B. Bales  
(Date received local registrar) (Registrar's signature) 297

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46  
 (c) City or town Rural 0303  
 (If outside city or town limits, write "RURAL")  
Dry Creek Township. 3  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 8  
 year 48 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 7-8-1948 to 7-8-1948  
 that I last saw him alive on 7-8-1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage 98 hrs.  
Hypertension 10 yrs.

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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?

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

23. Signature Of Callahan (M. D. or \_\_\_\_\_)Address Willow Springs, Mo. Date signed 7/17/48

RECEIVED 8-11-48  
District Health Officer No. 5,  
848514  
District File Number 8-13-48  
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.....  
Fred W. Barnes, Registered Apprentice No. 413  
working under my personal supervision.

Signed *J. C. Barnes*  
Licensed Embalmer No. 3379

P. O. Address Willow Springs, Miss

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.