

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30056**

FILED SEP 20 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **5631** Registrar's No. **153**

WRITE PLAINLY USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <b>LA Clede</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY <b>LA Clede</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>RURAL MAYFIELD</b> )	c. LENGTH OF STAY (in this place) <b>20 YRS</b>	c. CITY OR TOWN <b>Stoutland</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Home</b>		STREET ADDRESS (If rural, give location) <b>2 Mi. SW. Stoutland</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>PERRY</b> b. (Middle) <b>ROBERT</b> c. (Last) <b>SWANSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>9-9-55</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-7-96</b>	9. AGE (In years last birthday) <b>59</b> IF UNDER 1 YEAR Months <b>3</b> IF UNDER 24 HRS. Days <b>3</b> Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>SWEDEN</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>JOHN F. SWANSON</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>NERVIE Dougherty</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>1</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Rev. C. HAINES Stoutland</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Heart disease</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary Thrombosis</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>13 months</b> <b>13 mo.</b>
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19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>1375333</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Mayfield Trip Lodge MO</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>9-9-55</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept 9-9, 1955**, to **9-9, 1955**, that I last saw the deceased **alive on 9-9-55 and death occurred at 6 p.m.** from the causes and on the date stated above.

23a. SIGNATURE <b>C. E. Coatsworth</b> (Degree or title)	23b. ADDRESS <b>Stoutland Mo</b>	23c. DATE SIGNED <b>9-12-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>9-13-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Stoutland, Mo</b>
DATE REC'D BY LOCAL REG. <b>9-12-1955</b>	REGISTRAR'S SIGNATURE <b>Hella L. Play</b>	24d. LOCATION (City, town, or county) (State) <b>Stoutland Mo</b>
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John S. Simpson Hartsville</b>		

Received 9-19-55  
Laclede County Health Unit  
File No. 153  
Date Filed 9-19-55

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed James W. Wain

Licensed Embalmer No. 46

P. O. Address Springfield

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.