S. No.
M—5-42
7. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36856

FILED DEC 14 1942

Registration District No. ____ Primary Registration District No. 3011 Registrar's No. 138

1. PLACE OF DEATH:

(a) County Carroll

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

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

(d) Length of stay: In hospital or institution 6 weeks
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: 17

(a) State Mo (b) County Carroll 6

(c) City or town Rural — Dist. 6
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Charlotte Swearingin

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Female | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife W. M. Swearingin

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Jan (Month) 7 (Day) 1866 (Year)

8. AGE: Years 76 | Months 10 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Salsbury (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Farming

11. Industry or business ____

MOTHER FATHER

12. Name Leo H. Stein

13. Birthplace ____ (City, town, or county) Germany (State or foreign country)

14. Maiden name [illegible]

15. Birthplace ____ (City, town, or county) Ohio 1 (State or foreign country)

16. (a) Informant Ted Singenpater

(b) Address Tina Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-42 (Month) (Day) (Year)

(c) Place: burial or cremation Knoxville Mo.

18. (a) Signature of funeral director Clifford W. Austin

(b) Address Tina Mo.

19. (a) 11-14-42 (Date received local registrar) (b) Mrs James Rafferty (Registrar's signature)

1055

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 12 day 1942 year ____ hour 10 minute 10 A.M.

21. I hereby certify that I attended the deceased from Oct 22, 19____, to Nov 12, 1942, that I last saw h[illegible] alive on Nov 12 42, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Duration
Paralysis
Nephritis - V

Due to ____

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? (Specify type of place)

While at work? (e) Means of injury ____

23. Signature R. M. Benson (M. D. or other)

Address Carrollton Date signed Nov 12 42

RECEIVED
District Health Officer No. 8,
District File Number_____
Date Filed 12-11-42

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 Ben W Gibson

Licensed Embalmer No. 296

P. O. Address Carrollton 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.

V. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36856

Registration District No. 25 — Primary Registration District No. 2011 — Registrar's No. 138

1. PLACE OF DEATH:

(a) County Carroll

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

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

3. (a) PRINT FULL NAME Charlotte Swearingen

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) Jan (Day) 7 (Year) 1866

8. AGE: Years 76 | Months 10 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from ; 19 to 19 ; that I last saw h alive on ; 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral paralysis	
Due to (b) Nephritis Chronic Nephritis	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature R W Kinnear (M. D. or other)
Address Carrollton Mo Date signed

S-36856