S. No. 2
-11-10-39
. 5-17-39
I X21492

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. 36251

Registration District No. 775 Primary Registration District No. 6020-a Registrar's No. 66

1. PLACE OF DEATH

(a) County St. Francois

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

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

(d) Length of stay: In hospital or institution 1 (Specify whether In this community 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Farmington RR-1 (If outside city or town limits write "RURAL")

(d) Street No. 0 (If rural, give location)

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

3. (a) PRINT FULL NAME Joe Tom Swearingim

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race W

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

6. (b) Name of husband or wife Ida Bell Smith

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

7. Birth date of deceased Jan. (Month) 2 (Day) 1864 (Year)

8. AGE: Years 76 Months 9 Days 8 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

MOTHER FATHER

12. Name George Swearingim

13. Birthplace Don't know (City, town or county) (State or foreign country)

14. Maiden name Mary Smith

15. Birthplace Don't know (City, town or county) (State or foreign country)

16. (a) Informant Mary Gallagher

(b) Address Flat River Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof Oct. 12-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Chloride, Mo Farmington Undt Co.

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10 year 1940 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from 10-10-, 1940, to 10-10-, 1940; that I last saw him alive on 10-10-, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Fat embolus	
Due to: Fractured L. femur	6 hrs.
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) Accident

(b) Date of occurrence 10-10-40

(c) Where did injury occur? U.S. Highway 61 near Farmington (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway (Specify type of place)

While at work? (e) Means of injury: Auto struck by train

23. Signature H.W. Roeblen (M. D. or other) M.D.

Address Bonne Terre, Mo. Date signed 10/13/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

O. K. - Cozean, Registered Apprentice No.....,

working under my personal supervision.

Signed O. K. Cozean

Licensed Embalmer No. 4084

P. O. Address Farmington N

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.