

FILED NOV 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37640**

BIRTH NO. _____		REG. DIST. NO. <u>140</u>		PRIMARY REG. DIST. NO. <u>3024</u>		Registrar's No. <u>70</u>	
1. PLACE OF DEATH a. COUNTY <u>Howard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette</u>			c. LENGTH OF STAY (If in place) <u>9 wks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Franklin R.R.1 Booneslick</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Lee Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>R. R. #1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Stephen</u>			b. (Middle) <u>Patrick</u>		c. (Last) <u>Swearingen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 10 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 1, 1876</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Month <u>3</u> Day <u>9</u>	IF UNDER 4 HRS. Hour <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James Swearingen</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Lize Chipley</u>		14. NAME OF HUSBAND OR WIFE <u>Goldie Bobbitt</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> - - </u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lee Swearingen Fayette, Mo</u>			
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Primary Aplastic Anemia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					<u>2924</u>
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 <u>July</u> , 19 <u>49</u> , to <u>Nov 10</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>11-9</u> , 19 <u>49</u> , and that death occurred at <u>107 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Mr. J. Shaw M.D.</u> (Degree or title)				23b. ADDRESS <u>Fayette Mo.</u>		23c. DATE SIGNED <u>11-10-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>11/12/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Boonesboro Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Boonesboro, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11-10-49</u>		REGISTRAR'S SIGNATURE <u>Mary L. Shell</u> <u>404</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Halsh A. Carr</u>		ADDRESS <u>Fayette, Mo</u>	

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

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RECEIVED

NOV 15 1959

District Health Officer No. 8,

District File Number _____

Date Filed 11-18-59

JAN 11 1959

FEB 4 1959

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.

Signed _____

Ralph A. Carr

Signed _____
Student Embalmer

Licensed Embalmer No. 3340

P. O. Address Fayette 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, fact should be so stated above.