

FILED NOV 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37652

State File No.

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 173

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
a. COUNTY <u>Jackson</u>	b. CITY (If outside corporate limits, write RURAL and give town) <u>Rural Prairie Twp.</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Jackson</u>
c. LENGTH OF STAY (In this place) <u>2yr-10M-20D</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Brandwood</u>	d. STREET ADDRESS (If rural, give location) <u>5 Home</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>COLLINS</u>	b. (Middle) <u>C.</u>	c. (Last) <u>SWANEY</u>	<u>11-8-1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>8-28-1864</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Columbia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>✓</u>	13b. MOTHER'S MAIDEN NAME <u>✓</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Jackson Co. Home, Pt #4 - Indep. Mo</u>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>794X</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 12/14, 1946 to 11/8, 1949, that I last saw the deceased alive on 11/7, 1949 and that death occurred at 8:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. M. Greene M.D.</u>	(Degree or title)	23b. ADDRESS <u>Independence, Mo</u>	23c. DATE SIGNED <u>11/9/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>11/10/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Nov. 10, 1949</u>	REGISTRAR'S SIGNATURE <u>Donald C. Earnshaw 378</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. K. Goyes Sons</u>	ADDRESS <u>St. Louis, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 25 REC'D

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 _____

A. K. George

Signed _____

Student Embalmer

Licensed Embalmer No. 3645

P. O. Address Grandview, 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.