

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8372**

FILED MAR 22 1954

BIRTH NO. _____ REG. DIST. NO. **133** PRIMARY REG. DIST. NO. **3022** Registrar's No. **37**

1. PLACE OF DEATH a. COUNTY HARRISON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY HARRISON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bethany		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bethany	
d. FULL NAME OF HOSPITAL OR INSTITUTION Reid Hosp & Clinic		d. STREET ADDRESS (If rural, give location) 2004 E. MAIN	

3. NAME OF DECEASED (Type or Print) a. (First) OLLIE b. (Middle) M (only) c. (Last) SWAIN			4. DATE OF DEATH (Month) (Day) (Year) MARCH 14, 1954			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH OCT. 5, 1966	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Nurse wife		11. BIRTHPLACE (State or foreign country) HARRISON Co. Mo		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Alfred N. CAVE		13b. MOTHER'S MAIDEN NAME Martha E. MEERK		14. NAME OF HUSBAND OR WIFE William H. SWAIN (Doc)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mario Butler, Bethany, Mo	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 48 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 491 X	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) (Min)	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 **3-8, 1954** to **3-14, 1954**, that I last saw the deceased alive on **3-14, 1954**, and that death occurred at **10:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William M. Perry MD	23b. ADDRESS Bethany Mo	23c. DATE SIGNED 3-15-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE March 16, 1954	24c. NAME OF CEMETERY OR CREMATORY William Cemetery
24d. LOCATION (City, town, or county) (State) Bethany, Mo		

DATE REC'D BY LOCAL REG. 3/18/54	REGISTRAR'S SIGNATURE Zola Burris	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Donald W. Burgess, Bethany, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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APR 5

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
Student Embalmer

Signed Gerald W. Boggs

Licensed Embalmer No. 4762

P. O. Address Eagleville, 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.