

FILED JUN 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16134

BIRTH NO. _____ REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 3048 Registrar's No. 160

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give RURAL and give township) Maryville		c. CITY OR TOWN Graham	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 hr.		f. STREET ADDRESS (If rural, give location) 0740	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital			

3. NAME OF DECEASED a. (First) Virginia b. (Middle) Ellen c. (Last) Swartz			4. DATE OF DEATH (Month) (Day) (Year) 5-27-1955		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) never married	8. DATE OF BIRTH 4-5-1954		9. AGE (In years last birthday) 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Florida		12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Vern R. Swartz	13b. MOTHER'S MAIDEN NAME Suzanne Forecade	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Vern R. Swartz	ADDRESS Graham, Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Convulsions		INTERVAL BETWEEN ONSET AND DEATH 20m
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage		
	DUE TO (c) 331XF		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Graham Nodaway Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 5-25-1955	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall from chair

22. I hereby certify that I attended the deceased from **May 27, 1955**, to **May 27, 1955**, that I last saw the deceased alive on **May 27, 1955**, and that death occurred at **3:20 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. P. Jones M.D. (Degree or title)	23b. ADDRESS Maryville, Mo	23c. DATE SIGNED 5/27/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-31-1955	24c. NAME OF CEMETERY OR CREMATORY Graham Cemetery	24d. LOCATION (City, town, or county) (State) Graham Mo
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DATE REC'D BY LOCAL REG. 6-4-55	REGISTRAR'S SIGNATURE Klaus Holt	25. FUNERAL DIRECTOR'S SIGNATURE W. P. Johnson	ADDRESS Maryville
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *G M Peterson*.....

Licensed Embalmer No. *22*.....

P. O. Address *Maryland*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.