

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22825

FILED AUG 5 - 1955  
BIRTH NO. 57870-55 REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 137

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. LENGTH OF STAY (In this place) <u>2 days</u>		c. CITY OR TOWN <u>Calio Missouri</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Chillicothe hospital</u>				e. STREET ADDRESS (If rural, give location) <u>RFD# 6210 / 1</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>TERRY</u>			b. (Middle) _____		c. (Last) <u>SWEARINGIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 22, 1955</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>		8. DATE OF BIRTH <u>July 20, 1955</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Days Hours Min. <u>0 0 2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) <u>Chillicothe Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Andrew Swearingin</u>			13b. MOTHER'S MAIDEN NAME <u>Goldie V. (Nelson)</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>XX</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Andrew Swearingin Calio 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital atelectasis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity 6 mo 1 1/2 lb fetus</u> DUE TO (c) <u>7625</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 20, 1955</u> , to <u>July 22, 1955</u> , that I last saw the deceased alive on <u>July 20, 1955</u> , and that death occurred at <u>1:15 p.m.</u> from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Joseph F. Gale M.D.</u>				23b. ADDRESS <u>Chillicothe Mo</u>			23c. DATE SIGNED <u>7-22-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 23, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hebron</u>		24d. LOCATION (City, town, or county) (State) <u>Calio, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>7/22/55</u>		REGISTRAR'S SIGNATURE <u>Francisco B Neill</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clifford W Austin</u>				

(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed. Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

*Clefford W. Austin*

Licensed Embalmer No. 323

P. O. Address Texas

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated.