

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30005**

No. 300
10-48

FILED SEP 27 1955

BIRTH NO. _____ REG. DIST. NO. **159** PRIMARY REG. DIST. NO. **4249** Registrar's No. **52**

0500
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY JEFFERSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HILLSBORO		c. CITY OR TOWN ANTONIA	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) 3 MO.		e. STREET ADDRESS (If rural, give location) ANTONIA MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CEDAR GROVE NURSING HOME		f. STREET ADDRESS ANTONIA MO	
3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) _____ c. (Last) SWALLER		4. DATE OF DEATH (Month) (Day) (Year) SEPT 20 1955	
5. SEX M	6. COLOR OR RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN 27 1872
9. AGE (In years last birthday) 83		10. UNDER 1 YEAR Months _____	11. OVER 1 YEAR Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (City and State or Foreign Country) ROCK CREEK MO
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME JOSEPH SWALLER	
13b. MOTHER'S MAIDEN NAME MARY SLAVIK		14. NAME OF HUSBAND OR WIFE THERESIA SWALLER	
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. NONE	
17. INFORMANT'S SIGNATURE OR NAME THERESIA SWALLER		ADDRESS IMPERIAL 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 9-18-55 9-20-55 ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) 331X 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"/>		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)		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 9-18 , 19 55 , to 9-20 , 19 55 that I last saw the deceased alive on 9-20 , 19 55 , and that death occurred at 6:30 AM , from the causes and on the date stated above.	
23a. SIGNATURE R. E. Preece (Degree or title) D.O.		23b. ADDRESS De Soto Mo.	
23c. DATE SIGNED 9-21-55		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE SEPT 23 1955		24c. NAME OF CEMETERY OR CREMATORY ST JOSEPH CEMETERY	
24d. LOCATION (City, town, or county) (State) KIMMSWICH MO		25. FUNERAL DIRECTOR'S SIGNATURE HEILIGTAG FUNERAL HOME ADDRESS IMPERIAL MO	
DATE REC'D BY LOCAL REG 9-23-55		REGISTRAR'S SIGNATURE Kathleen Mander ADDRESS 141	

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED

SEP 24 1955

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 *Elmer A. Aligtag*.....

Licensed Embalmer No. 357.....

P. O. Address.....

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 above.