

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39570

State File No.

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 5076 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Nebraska</u> b. COUNTY _____	
b. CITY OR TOWN <u>rural Nicholas</u>	c. LENGTH OF STAY (In this place) <u>1 day</u>	c. CITY OR TOWN <u>unknown</u>	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		e. STREET ADDRESS (If rural, give location) <u>825 E 8th</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lillie</u> b. (Middle) _____ c. (Last) <u>Swartz</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 19-1955</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>Indian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April - 1900</u>	9. AGE (In years last birthday) <u>55</u>	if UNDER 1 YEAR Days _____	if UNDER 2 HRS. Hours _____	if UNDER 15 MIN. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traveler</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Traveler</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Okla.</u>	12. CITIZEN OF WHAT COUNTRY? _____
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13a. FATHER'S NAME <u>Simon Bigleaf</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Bob Swartz</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	(If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Bob Swartz - Washhill Neb.</u>	ADDRESS _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>GANGRENE OF BOTH FEET &</u>	ANTECEDENT CAUSES		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>LEGS</u> DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>455X</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) _____	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. C. Gallus</u> (Degree or title) <u>Cora</u>	23b. ADDRESS <u>Rock Port Mo</u>	23c. DATE SIGNED <u>12-20-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Dec. 20/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washhill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Rock - Port Mo</u>
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DATE REC'D BY LOCAL REG. <u>Dec 22, 1955</u>	REGISTRAR'S SIGNATURE <u>Harvin H. Schober</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Bertman</u> ADDRESS <u>Funeral Home - Rock - Port</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

820

no

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... *E. C. Pentam*

Licensed Embalmer No... *1763*

P. O. Address *Rocky Point*

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.