

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12456

State File No. _____

FILED MAY 7 1956

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>479</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>12 yrs</u>		c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>D.o.a. Mo. Meth. Hospt.</u>				e. STREET ADDRESS (If rural, give location) <u>212 Alabama St.</u> <i>01170</i>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u>			b. (Middle) <u>M. L.</u>			c. (Last) <u>Swearingen</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 24, 1956</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>May 1, 1867</u>	
9. AGE (In years last birthday) <u>88</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Clinton Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Chapman</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Ann Roush</u>			14. NAME OF HUSBAND OR WIFE <u>J.S.J. Swearingen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. William Sonner St. Joseph, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion approx</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Hypertensive Cardio-vascular disease</u> DUE TO (c) _____ 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dr. Taber saw patient in my absence 4-24-56</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				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>3-3</u> , <u>1954</u> , to <u>4-24</u> , <u>1954</u> , that I last saw the deceased alive on <u>1-24</u> , <u>1953</u> , and that death occurred at <u>2:40a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm B. Roehrig</u>				23b. ADDRESS <u>316 No 10th St Joseph Mo</u>		23c. DATE SIGNED <u>4/26/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Apr. 26, 56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Perrin Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Perrin, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>May 1, 1956</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl A. Clark</u>		ADDRESS <u>Clark Funeral Home St. Joseph, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.....
Earl Clark

Licensed Embalmer No.

P. O. Address.....
Albany

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.