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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 0 27 584
STATE FILE NUMBER

FILED AUG 26 1957

Registration District No. 42 Primary Registration District No. I000 Registrar's No. 888

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clinton		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Rural		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sisters Hosp		Length of stay in lb 5 Day	d. STREET ADDRESS R.F.D Gower, Mo. (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) LAWANNA First None Middle Swope Last			4. DATE OF DEATH Aug 1 1957 Month Aug Day 1 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1967		9. AGE (In years last birthday) 5 IF UNDER 1 YEAR Months 5 Days 5 Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X		10b. KIND OF BUSINESS OR INDUSTRY X X		11. BIRTHPLACE (City and state or country) R.F.D. Gower, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Ivan Albert Swope		
14. MOTHER'S MAIDEN NAME Cora Mae Swindler			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>		
16. SOCIAL SECURITY NO. None			17. INFORMANT Ivan Swope Address Gower, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Prematurity (3 mo) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 774 X					INTERVAL BETWEEN ONSET AND DEATH 5 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour 774 X Month 774 X Day 774 X Year 774 X a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Plattsburg Mo. COUNTY Plattsburg STATE Mo.	
21. I attended the deceased from July 28-31 to Aug 1-57 and last saw her alive on July 28 57 Death occurred at 774 X on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE W.B. Spalding MD (Degree or title)		22b. ADDRESS Plattsburg Mo.		22c. DATE SIGNED Aug 1 57	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE Aug 1 1957		23c. NAME OF CEMETERY OR CREMATORY Plattsburg Mo	
23d. LOCATION (City, town, or county) Plattsburg Mo.		23e. STATE Mo.		23f. COUNTY Plattsburg	
24. FUNERAL DIRECTOR D.D. Lyon ADDRESS Plattsburg, Mo		25. DATE RECD. BY LOCAL REG. Aug 5, 1957		26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton	

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 *Philip S. Good*.....

Licensed Embalmer No. *49*

P. O. Address *St. Louisburg*

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.