

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 23 1957

32795

STATE FILE NUMBER

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 286

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Mo b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maryville		c. CITY OR TOWN Graham	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital		d. STREET ADDRESS (If outside, give location) 3 hrs	

3. NAME OF DECEASED (Type or print) Robert H Swank			4. DATE OF DEATH 9 11 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2 1883	9. AGE (In years last birthday) 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Gen Store owner		10b. KIND OF BUSINESS OR INDUSTRY General Store	11. BIRTHPLACE (City and state or country) Graham, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Swank		14. MOTHER'S MAIDEN NAME Elmyra McRoberts	
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. unknown	17. INFORMANT Address Mrs Frances Swank, Graham, 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) gastric hemorrhage + shock - History: ulcers -		INTERVAL BETWEEN ONSET AND DEATH 5 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5400		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 Month, Day, Year 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 COUNTY STATE
21. I attended the deceased from 9/11/57 to 9/11/57 and last saw her alive on 9/11/57 Death occurred at 7 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) [Signature]	22b. ADDRESS Maryville, Mo.	22c. DATE SIGNED 9/14/57

23a. BURIAL, CREMATION, or other disposition (Specify) burial	23b. DATE 9/15/1957	23c. NAME OF CEMETERY OR CREMATORY Graham Cmtery	23d. LOCATION (City, town, or county) (State) Graham, Mo.
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24. UNDERTAKER DIRECTOR ADDRESS [Signature]	25. DATE RECD. BY LOCAL REG. 9-21-57	26. REGISTRAR'S SIGNATURE Bess Holt
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(Licensed Embalmer's Statement on Reverse Side)

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

MEDICAL CERTIFICATION

79 0

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 *G. M. Stebbins*.....

Licensed Embalmer No. *30*

P. O. Address *Princeton*

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.