

FILED NOV 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43284  
STATE NUMBER

Registration District No. 360 Primary Registration District No. 2076 Registrar's No. 211

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Nevada</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>217 N. Colorado</u>		Length of stay in lb <u>25 years</u>	d. STREET ADDRESS (If outside, give location) <u>1217 N. Colorado</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>Alice</u> Last <u>Swails</u>			4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1957</u>		
5. SEX <u>Fm</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1883</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____
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>USA</u>	11. BIRTHPLACE (City and state or country) <u>Harvard, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>J. F. Spencer</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Holdenbrand</u>		14. NAME OF HUSBAND OR WIFE <u>F.A. Swails</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 <u>F.A. Swails</u> Address <u>Nevada, Mo.</u> <u>1217 N. Colorado.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lost Compensation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Approx 1 wk</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Aortic &amp; Tricuspid Stenosis</u>					<u>Approx. 3 yrs</u>
DUE TO (c) <u>Hypertension</u>					<u>3 or 4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4211</u>					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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Oct. 19, 1956</u> to <u>Nov. 1, 1957</u> and last saw her alive on <u>Nov 1, 1957</u> Death occurred at <u>8:20 pm</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>B. T. Marshall D. C.</u>			22b. ADDRESS <u>Nevada, Missouri</u> <u>314-A West Cherry St.</u>		22c. DATE SIGNED <u>Nov 15, 57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1957</u> <u>November 16</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moore Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Nevada Missouri</u>
24. FUNERAL DIRECTOR <u>Ferry Funeral Home</u>		ADDRESS <u>Nevada, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-18-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Securing the medical certificate in this specific manner required by 193.140 MORS 1949.  
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.

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 *L. Douglas Ferry* .....

Licensed Embalmer No. *4-960* .....

P. O. Address *Nevada, N.* .....

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.