

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43756**

FILED JAN 2 1958

BIRTH NO. _____ REG. DIST. NO. **59** PRIMARY REG. DIST. NO. **4097** Registrar's No. **187**

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Harrisonville		c. CITY OR TOWN Harrisonville	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 5 days		e. STREET ADDRESS (If rural, give location) 7 miles SW (Grand River Township)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Memorial Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) EDWARD	c. (Last) SWEARINGEN	4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1957
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 2, 1881	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 24 HRS: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) Pomona, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Samuel Swearingen	13b. MOTHER'S MAIDEN NAME Sarah Woods	14. NAME OF HUSBAND OR WIFE Effie F. Swearingen
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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. non	17. INFORMANT'S SIGNATURE OR NAME Mrs. Effie Swearingen	ADDRESS Harrisonville, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BILATERAL BRONCHOPNEUMONIA		3 Days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CEREBRAL THROMBOSIS DUE TO (c) CEREBRAL ARTEROSCLEROSIS		5 DAYS 5 YEARS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? 2 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) 332x
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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 **FEBR**, 19**57**, to **DEC 22**, 19**57**, that I last saw the deceased **on 12-21-57**, and that death occurred at **9:15 AM** the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) MD	23b. ADDRESS HARRISONVILLE MO	23c. DATE SIGNED 12-23-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-24-57	24c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery	24d. LOCATION (City, town, or county) (State) Oregon, Missouri
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DATE REC'D BY LOCAL REG. Dec 24, 1957	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Harrisonville, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

57

RECEIVED

DEC 30 1957

HEALTH DEPARTMENT

JAN 13 1958

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 *Robert W. Cookinon*

Licensed Embalmer No. *4902*

P. O. Address *Harmond*

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.