

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022105

STATE FILE NUMBER

FILED JUL 14 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3108

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1-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LONG LANE</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>3522 WALNUT ST.</u>		Length of stay in 1b <u>2 MONTHS</u>	d. STREET ADDRESS (If outside, give location) <u>0300 -</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>SWIFT</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1958</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 3, 1873</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	9c. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (City and state or country) <u>o</u> <u>BUFFALO, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JIM BENT FRANKLIN</u>	
13b. MOTHER'S MAIDEN NAME <u>ELSIE SLACK</u>		14. NAME OF HUSBAND OR WIFE <u>THOMAS B. SWIFT</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 Address <u>VIRGIL SWIFT, 4215 SANDUSKY K.C. KS.</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>Coronary arterial occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary arterial sclerosis</u> DUE TO (c) <u>Dementia + generalized arterio sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 45 min</u> <u>Indef.</u>
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 <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 4, 1958</u> to <u>June 22</u> and last saw her alive on <u>June 4, 1958</u> Death occurred at <u>7:45</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Philip W. Reister MD</u>		22b. ADDRESS <u>518 Apple Bldg K.C. Mo</u>	22c. DATE SIGNED <u>6/23/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JUNE 23, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>BUFFALO MISSOURI</u>
24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOMER'S SONS, KANSAS CITY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-23-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Philip D. Reister USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



SEP 25 1957

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 *Chester K Brown*

Licensed Embalmer No. *4931*

P. O. Address *KOYNO*

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.