

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000354

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 52

300

-57-

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> <b>0117</b> OR <b>0</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. St. Josephs Hosp.</b>		Length of stay in 1b <b>life</b>	d. STREET ADDRESS (If outside, give location) <b>812 S. 11th St.</b>
3. NAME OF DECEASED (Type or print) First <b>DARRELL</b> Middle <b>DEAN</b> Last <b>SWANEY</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>14,</b> Year <b>1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	9. AGE (In years last birthday) Months <b>2</b> Days <b>9</b> IF UNDER 1 YEAR Hours Min. <b>2 9</b>
11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Forest Dean Swaney</b>		13b. MOTHER'S MAIDEN NAME <b>Della Morehouse</b>	14. NAME OF HUSBAND OR WIFE <b>---</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Forest D. Swaney, 812 S. 11th, St. Joseph, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>aspiration</b> DUE TO (c) <b>4210</b>			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 <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 <b>13</b>
21. I attended the deceased from <b>11-5-58</b> to <b>1-14-59</b> and last saw her/him alive on <b>1-14-59</b> Death occurred at <b>12:15</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Clement C Dulmont</b> (Degree or title) <b>C</b>		22b. ADDRESS <b>St Joseph Mo</b>	22c. DATE SIGNED <b>1-14-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>1/14/1959</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Hopkins Missouri</b>
24. FUNERAL DIRECTOR <b>Hester Bowman</b> ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Jan. 15, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>

All diseases in Part I must be causally related.  
 Dr. Clement C Dulmont  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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 *William Spalding* .....  
Licensed Embalmer No. *4535* .....  
P. O. Address *3155 10th St* .....

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.