

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007694

STATE FILE NUMBER

2 1725

FILED MAR 10 1959

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1149 Louisville		d. STREET ADDRESS 1149 Louisville	
3. NAME OF DECEASED (Type or print) First Middle Last LEO Cordelia Tanner		4. DATE OF DEATH Month Day Year Feb. 17, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4th-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 66
13. FATHER'S NAME Charles Swearingen		11. BIRTHPLACE (City and state or country) Fort Scott Kansas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. none		14. MOTHER'S MAIDEN NAME Lillie Mae Womack	
17. INFORMANT Mr Andy Tanner 1149 Louisville Ave.		Address St. Louis 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) <i>Cerebral vascular disease probably cerebral hemorrhage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>331X</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			19. INTERVAL BETWEEN ONSET AND DEATH Immediate
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 Jan 1958 to Feb 17/59 and last saw her alive on Feb 17/59 Death occurred at 8:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Reyn Berg</i> (Degree or title)		22b. ADDRESS 32038 Grand	
		22c. DATE SIGNED 2/18/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/18/59	
23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri.	
24. FUNERAL DIRECTOR S.R. Lupton and Sons 7233 Delmar Blv'd.		25. DATE RECD. BY LOCAL REG. FEB 18 '59	
		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Part I must be causally related. Certifier cannot certify to a death due to natural causes.

06 00  
049 2  
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11:30 To 3:00 A.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Clarence A. Murray*

Licensed Embalmer No.....  
P. O. Address.....  
*St. Louis*

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.