

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032058

FILED VS OCT 13 1959

Registration District No. 128 Primary Registration District No. 2003 Registrar's No. 1045

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>7 hrs.</u>		c. CITY OR TOWN <u>K. C. Mo.</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>Burke Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Billy</u> Middle <u>Joe</u> Last <u>Swanigan</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 3 1939</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u>	IF UNDER 24 HR Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Buffalo, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13a. FATHER'S NAME <u>Albert O. Swanigan</u>			13b. MOTHER'S MAIDEN NAME <u>Gloria Ann Hayes</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Albert O Swanigan</u> Address <u>K. C. Mo.</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>Intracranial Hemorrhage</u> DUE TO (b) <u>Breech Presentation</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Premature Birth</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ 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 <u>10/4/59</u> to <u>10/4/59</u> and last saw her/him alive on <u>10/4/59</u> Death occurred at <u>6:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Paul Busch M.D.</u> (Degree or title)				22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>10/7/59</u> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>Oct. 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>		23d. LOCATION (City, town, or county) <u>Dallas Co. Missouri</u>				
24. FUNERAL DIRECTOR <u>Allen W. Vaughan</u> ADDRESS <u>Urbana, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10-8-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Meeter</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urban

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.