RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-000879
STATE FILE NUMBER

ED VS FEB 8 1960

Registration District No. 100 Primary Registration District No. 3605 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY: Dent
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Salem
Length of stay in 1b: 4yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: at home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Dent
c. CITY OR TOWN: Salem
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): West Salem
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Goldie Middle: Ioma Last: Swank
4. DATE OF DEATH: Month: Feb Day: 5 Year: 1960
5. SEX: female
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-31-00
9. AGE (last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: X
11. BIRTHPLACE (City and state or country): Emporia Kans
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: Isaac N Smith
13b. MOTHER'S MAIDEN NAME: Elenear Workman
14. NAME OF HUSBAND OR WIFE: Antrim Swank
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): X
16. SOCIAL SECURITY NO.: 210-16-24-85
17. INFORMANT: Antrim Swank Address: rt 4 Salem Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Natural Causes — INTERVAL BETWEEN ONSET AND DEATH: X
(Verdict of the Coroners jury)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 2 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Martin M. Hart M.D. (Degree or title) (Local registrar)
22b. ADDRESS: Salem Mo
22c. DATE SIGNED: 6 Feb 60

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: Feb 7 -60
23c. NAME OF CEMETERY OR CREMATORY: Cedar Grove Cem
23d. LOCATION (City, town, or county) (State): Salem Dent Co Mo

24. FUNERAL DIRECTOR: Spencer Funeral Home Inc ADDRESS
25. DATE RECD. BY LOCAL REG.: 2/5/60
26. REGISTRAR'S SIGNATURE: M. M. Hart, M. D. by [illegible]

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.