

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-018668

STATE FILE NUMBER

Registration District No. **301**

Primary Registration District No. _____

Registrar's No. **37**

AMENDED

FILED JUN 5 1961

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| 1. PLACE OF DEATH a. COUNTY Ripley | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ripley | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN DONIPHAN | Length of stay in 1b. 60 yrs. | c. CITY OR TOWN DONIPHAN | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Hwy #160 W. Doniphan | | d. STREET ADDRESS (If outside, give location) R #3 | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last George Washington Swift | | | 4. DATE OF DEATH Month Day Year MAY 29 1961 | |
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| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5-22-1882 | 9. AGE (last birthday) 79 | IF UNDER 1 YEAR: Months Days Hours Mins. | IF UNDER 24 HR: |
|-----------------------|----------------------------------|---|--------------------------------------|----------------------------------|--|-----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Timber | 11. BIRTHPLACE (City and state or country) Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Charlie Swift | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Augusta Swift |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT: Augusta Swift Address: Doniphan Mo. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) Hit by Car | | INTERVAL BETWEEN ONSET AND DEATH: 2 hours |
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Conditions, if any, which gave rise to above cause: (a), stating the underlying cause: last:
DUE TO (b) **fractured pelvis, ruptured bladder**
DUE TO (c) **fractured pelvis & both hips**

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| 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.) |
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|---|---|--|------------------------------|---------|--------|
| 20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. Month, Day, Year: _____ | 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: |
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| 21. I attended the deceased from: June 1957 to May 29 and last saw him alive on: May 29, 1961 Death occurred at: 10:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) Frank Johnson MD | 22b. ADDRESS Doniphan, Mo | 22c. DATE SIGNED (State) 6/1/61 |
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| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL | 23b. DATE MAY 31, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Lone Star Cemetery | 23d. LOCATION (City, town, or county) Ripley County, Mo. |
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| 24. FUNERAL DIRECTOR: Edwards Funeral Home Doniphan, Mo. | 25. DATE RECD. BY LOCAL REG. 6-2-61 | 26. REGISTRAR'S SIGNATURE Flava Broz |
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFRAYSIT OF
ITEM NO. SHOULD READ

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 Gene Starnent

Licensed Embalmer No. 4809

P. O. Address Naylor, W

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.