

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043719

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1262

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in lb 75 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hillside Nursing Home		d. STREET ADDRESS (If outside, give location) 603 N. 5th St.	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) CORA SWENSON			4. DATE OF DEATH December 5, 1961		
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 4/26/1870		
9. AGE (last birthday) 91			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 own home		11. BIRTHPLACE (City and state or country) Iowa	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Harrison Newton		13b. MOTHER'S MAIDEN NAME Martha Newlon	
14. NAME OF HUSBAND OR WIFE Peter		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 Mrs. Katharine White, 603 N. 5th, St. Joseph, 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) Cerebrovascular Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	

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) Fracture of the neck of the left femur		
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.) Patient fell at home.		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 11/13/61			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home			20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Joseph, Buchanan, Missouri		

21. I attended the deceased from 11/20/61 to 12/5/61 and last saw her her live on 11/20/61		
Death occurred at 10:00 a. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) John R. McDaniel, M.D.		22b. ADDRESS 902 Edmond, St. Joseph, Mo.
22c. DATE SIGNED 12/7/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12/7/1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph Mo.		

24. FUNERAL DIRECTOR ADDRESS Heston-Bowman, St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 11, 1961	26. REGISTRAR'S SIGNATURE Mrs. Clark Gordell
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 J.R. McDaniel
 SHOULD READ
 THIS RECORD ARE AS FOLLOWS
 AMENDMENTS ON

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 St. Joseph, Mo.

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.