

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044426

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 3025 Registrar's No. 164

AMENDED

FILED JAN 2 1962

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEST PLAINS</u>		Length of stay in 1b	c. CITY OR TOWN <u>SOUTH FORK</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>HOSPITAL</u>			Inside Limits Yes <input 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>PINKNEY</u> Middle <u>SWEARINGER</u> Last			4. DATE OF DEATH Month <u>12</u> - Day <u>19</u> - Year <u>61</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-8-1980</u>	9. AGE (last birthday) <u>81</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>OLDEN MO</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>ERASMUS SWEARINGER</u>		13b. MOTHER'S MAIDEN NAME <u>REBECCA WILL</u>		14. NAME OF HUSBAND OR WIFE <u>GORDON SWEARINGER SIKESTON, MO</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <u>GORDON SWEARINGER SIKESTON, 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>CEREBRAL HEMORRAGE</u> DUE TO (b) <u>SENILITY</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH	
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		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ 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	
21. I attended the deceased from <u>1950</u> to <u>12-19-61</u> and last saw her/him alive on <u>12-19-61</u> Death occurred at <u>11:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>J. B. Stoll M.D.</u>			22b. ADDRESS <u>WEST PLAINS MO</u>		22c. DATE SIGNED <u>12-25-61</u>	
23a. BURIAL, CREMATION, (REMOVAL) (Specify) <u>BURIAL</u>	23b. DATE <u>12-21-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MACKAY</u>		23d. LOCATION (City, town, or county) (State) <u>Pomona MO</u>		
24. FUNERAL DIRECTOR <u>CARTER'S WEST PLAINS MO</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-28-61</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		

JAN 3 1962

**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 *Beland Carter*

Licensed Embalmer No. 4516

P. O. Address *West Plains*

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.