

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002057

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 319

FILED FEB 6 1962

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 4 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 401 EAST 36TH STREET HYDE PARK NURSING HOME		d. STREET ADDRESS (If outside, give location) 217 WEST ARMOUR BLVD.	
Inside Limits 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) First ANNA Middle L Last SWENSON			4. DATE OF DEATH Month JANUARY Day 16 Year 1962
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 4/14/72
9. AGE (last birthday) 90 89		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) CLAY COUNTY, KANS.
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME PRESTON LOOFBOURROW	
13b. MOTHER'S MAIDEN NAME SARAH ARNETT		14. NAME OF HUSBAND OR WIFE CARL A. SWENSON	
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 HAZEL L. SWENSON
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A.		INTERVAL BETWEEN ONSET AND DEATH 12 HRS.	
DUE TO (b) Essential Hypertension.			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary Insuff.		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 _____ 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 Oct 61 to 16 Jun 62 and last saw her alive on 16 Jun 62 Death occurred at 9:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert M. Myers		22b. ADDRESS 906 Grand Ave.	22c. DATE-SIGNED 16 Jan 62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE JAN. 17, 1962	23c. NAME OF CEMETERY OR CREMATOR WILLOW SPRINGS CEMETERY
23d. LOCATION (City, town, or county) WILLOW SPRINGS MISSOURI		23e. DATE RECD. BY LOCAL REG. 1-18-62	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		26. REGISTRAR'S SIGNATURE Ruth Long	

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address K. C., 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.