

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-046708

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 142 Primary Registration District No. 55876 Registrar's No. 68 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED **F**

LED DEC 26 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

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>Caldsberry</u>		c. CITY OR TOWN <u>Mtn. View, (Rural)</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Route 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Marcus</u> Middle <u>Andrew</u> Last <u>Swinson</u>		4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/8/12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Greenway, Ark.</u>
13a. FATHER'S NAME <u>W.A. Swinson</u>		13b. MOTHER'S MAIDEN NAME <u>Annie A. Shelby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[Redacted]</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		17. INFORMANT <u>W.A. Swinson</u> Address <u>Mtn. View, Mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cor pulmonale; pulmonary emphysema</u>		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.)	
20c. TIME OF INJURY Hour <u>2-0</u> a.m. p.m.	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.)	20f. CITY, TOWN, OR LOCATION <u>Mtn. View, Mo.</u>
21. I attended the deceased from <u>Dec. 11</u> to <u>Dec. 12</u> and last saw her/him alive on <u>Dec. 11, 1962</u>		Death occurred at <u>Dec 12, 1962</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>M.C. Walton M.D.</u> (Degree or title)		22b. ADDRESS <u>Mtn. View, Mo.</u>	22c. DATE SIGNED <u>12-15-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/15/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mitchell Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Greenway, Arkansas</u>
24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn. View, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-21-62</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>

USE BLACK INK OR TYPEWRITER RIBBON

To Doctor 4:45 P.M. 12/14/62

Rec'd from Dr. 10:00 A.M. 12/20/62

To Local Registrar 10:15 A.M. 12/20/62

**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 Charles D. Cartain

Licensed Embalmer No. 5107

P. O. Address Wm. Linn, 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.