

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010799

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 45

VS 300
 Rev. 4/59

1 0190
 2 0190
 3
 4 0
 5 1
 6
 7 1
 8 0
 9 4200
 10
 11
 12 90-2
 13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived.) If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Benton Twp.</u> Length of stay in lb <u>15 years</u>		c. CITY OR TOWN <u>Rural Benton Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mile NW of Harrisonville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1 mile NW of Harrisonville</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NOTE</u> Middle <u>SWEARINGER</u> Last <u>SWEARINGER</u>			4. DATE OF DEATH <u>Mar 23 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1875</u>
9. AGE (last birthday) <u>85</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Chandlerville Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Andrew Swearingner</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Keen</u>
14. NAME OF HUSBAND, OR WIFE <u>Araette Swearingner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>ARAETTE SWEARINGNER</u> Address <u>Harrisonville Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</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 _____ 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 <u>Mar 8, 1963</u> to <u>Mar 23</u> and last saw him alive on <u>Mar 8, 1963</u> Death occurred at <u>11:30</u> <u>PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul Green D.O.</u> (Deceased's title)		22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>3-25-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar 25 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	23d. LOCATION (City, town or county) <u>Harrisonville</u> (State) <u>Mo.</u>
24. FUNERAL DIRECTOR <u>Penningburg</u> ADDRESS <u>Harrisonville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3/26/63</u>	26. REGISTRAR'S SIGNATURE <u>Ray J. Lebee</u>

USE BLACK INK OR TYPEWRITER RIBBON

Dr Green

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

Frank Kennenbeger 3rd

Licensed Embalmer No.

5073

P. O. Address

Harrisonville, 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.