

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011442

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 49

STATE FILE NUMBER

FILED MAR 20 1963

1. PLACE OF DEATH a. 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. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Plains Memorial</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Howell</u> c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Midway Hotel</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>P.</u> Last <u>Swain</u>			4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>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>10/13/1894</u>	9. AGE (last birthday) <u>68</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Harlin Iowa</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>	
13a. FATHER'S NAME <u>Harry Swain</u>		13b. MOTHER'S MAIDEN NAME <u>? Platt</u>		14. NAME OF HUSBAND OR WIFE <u>Elizabeth Swain</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>H. E. Swain, Omaha, Nebraska</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) <u>ASHD</u> DUE TO (c) <u>GAS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulm. emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs?</u> <u>?</u> <u>?</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 _____ 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 _____ to _____ and last saw him alive on <u>3-9-63</u> Death occurred at <u>8:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>W. E. Wilson, MD</u>		22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>3-12-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/15/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-14-63</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

DO NOT WRITE ON THIS STUD	AMENDED	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
VS 300 Rev. 4/59								
10465								
20465								
3								
4	0							
5	1							
6								
7	1							
8	2							
9	200							
10								
11								
12	5-0							
13	1-0							

USE BLACK INK OR TYPEWRITER RIBBON

JUN 11 1963

MAR 27 1963

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 Leland Carter

Licensed Embalmer No. 4516

P. O. Address West Plains 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.