

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036496

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 119 Primary Registration District No. 1002 Registrar's No. 4751 STATE FILE NUMBER

**FILED SEP 18 1963**

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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

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b> Length of stay in 1b <b>1 YEAR</b>		c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HOME</b> <b>540 HIGHLAND RIVERSCENE NURSING</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>540 HIGHLAND AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE SWAN</b>			4. DATE OF DEATH Month Day Year <b>AUG 25 1963</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE - AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	11. BIRTHPLACE (City and state or country) <b>ATG HISON, KANS.</b>
13a. FATHER'S NAME <b>ERNEST D. ROE</b>		13b. MOTHER'S MAIDEN NAME <b>MARY ANN DEMPSEY</b>	14. NAME OF HUSBAND OR WIFE <b>CHARLES SWAN</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>GRACE A. DILLON, 1807-29TH AVENUE, SAN FRANCISCO, CALIF.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>2 yr.</b>
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 checked="" 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 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 <b>June 1963</b> to <b>Aug. 1963</b> and last saw her alive on <b>July 23, 1963</b> Death occurred at <b>8-25-63 5:40 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Mary H. Moser MD</b>		22b. ADDRESS <b>4914 Skyline Dr. Mission, K.</b>	22c. DATE SIGNED <b>8-26-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>AUG. 27, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, Mo.</b>
24. FUNERAL DIRECTOR, <b>131 IRON CREEK DOWNS</b> <b>D.W. NEWCOMERS SONS, K.C., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-27-63</b>	26. REGISTRAR'S SIGNATURE <b>Bessie Smith</b>

USE BLACK INK OR TYPEWRITER RIBBON

W. A. Hoover  
D. A. Hospital - at death in lobby  
12:00 Noon

**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 *W. A. Hoover*

Licensed Embalmer No. 4096

P. O. Address W. C. Hoover

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.