

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20415
STATE FILE NUMBER

FILED JUN 17 1957

Registration District No. 73 Primary Registration District No. 3014 Registrar's No. 76

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Clax</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clax</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Liberty</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>462 N. Water</u> Length of stay in 1b <u>years</u> | | d. STREET ADDRESS (If outside, give location) <u>462 N. Water</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>SARAH SWADER</u> First Middle Last | | | 4. DATE OF DEATH <u>June 3rd 1957</u> Month Day Year |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 12, 1872</u> |
| 9. AGE (In years last birthday) <u>85</u> | | 10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (City and state or country) <u>Kentucky</u> | |
| 13. FATHER'S NAME <u>Williams</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</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>None</u> | |
| 17. INFORMANT <u>Leona Mitchell</u> | | Address <u>Liberty, Mo.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of breast metastatic to kidney</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>54</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u> | | 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>25 Jan 57</u> to <u>3 June 57</u> and last saw <u>her</u> <u>him</u> alive on <u>3 June 57</u> . Death occurred at <u>3:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>J. W. Waterman, M.D.</u> | | 22b. ADDRESS <u>Liberty, Mo</u> | |
| 22c. DATE SIGNED <u>6/7/57</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE <u>June 6, 1957</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u> | |
| 23d. LOCATION (City, town, or county) <u>Liberty</u> | | (State) <u>Missouri</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Church-Archer Co. Liberty Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-7-57</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u> | | | |

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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 *John Forberg*.....

Licensed Embalmer No. 44

P. O. Address In Centre

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.