

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0000837

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 17 Primary Registration District No. 4141 Registrar's No. 56

FILED FEB 8 1967

VS 300  
Rev. 4/59

1 0260  
2 0260  
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4 1  
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7 0  
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12 90-0  
13 1-0

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>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centertown, Mo</u>		Length of stay in 1b <u>6 Days</u>	c. CITY OR TOWN <u>Centertown, Mo</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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Centertown, Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Ethlyn</u> Last <u>Swearingen</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1967</u>
5. SEX <u>Female</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>10/14/19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (last birthday) <u>47</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>Elston, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Squire Lister</u>		13b. MOTHER'S MAIDEN NAME <u>Ethel Buckner</u>	14. NAME OF HUSBAND OR WIFE <u>Boyd Swearingen</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>UnKnown</u>	17. INFORMANT Address <u>Boyd Swearingen-Centertown, 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>Acute coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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			INTERVAL BETWEEN ONSET AND DEATH
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 <u>1963</u> to <u>1/30/67</u> and last saw her <sup>her</sup> alive on <u>1/30/67</u> Death occurred at <u>12/30 A</u> m of the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. J. Swearingen MD</u> (Degree or title)		22b. ADDRESS <u>515 E HIGH - Jeff. City, Mo</u>	22c. DATE SIGNED <u>2/1/67</u>
23a. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Centertown Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Centertown, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Bowlin Funeral Home-California, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-2-67</u>	26. REGISTRAR'S SIGNATURE <u>Norma Miller</u>

USE BLACK INK OR TYPEWRITER RIBBON

FEB 9 1967

4-1-68

**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 R. Beula  
Licensed Embalmer No. 5150

P. O. Address California, Mo.  
65018

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.