

FILED AUG 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22490

BIRTH NO. _____ REG. DIST. NO. 14 PRIMARY REG. DIST. NO. 5064 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY Barton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE California b. COUNTY 911	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Liberal (Rural) Leroy 1 mo. 25 da.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Los Angeles 4	
d. FULL NAME OF HOSPITAL OR INSTITUTION Leroy Turn 11		d. STREET ADDRESS (If rural, give location) 0	
3. NAME OF DECEASED (Type or Print) a. (First) Ear b. (Middle) Swearingen c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 27, 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Divorced	8. DATE OF BIRTH Jan. 21, 1881
9. AGE (In years last birthday) 68		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Decorator	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Wm. Swearingen		13b. MOTHER'S MAIDEN NAME Henrietta Glascock	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Jess Swearingen, Liberal, Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Angina Pectoris ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 0 DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4/20/2	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) 0	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 0 0 0	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 0		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 0			
22. I hereby certify that I attended the deceased from July 6, 1949, to July 27, 1949, that I last saw the deceased alive on July 26, 1949, and that death occurred at 1:30 P.M., from the causes and on the date stated above.			
23a. SIGNATURE D. L. Eddleman M.D.		23b. ADDRESS Liberal Mo	
23c. DATE SIGNED 7/29/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 29, 1949	
24c. NAME OF CEMETERY OR CREMATORY Rosebank		24d. LOCATION (City, town, or county) (State) Mulberry Kans	
DATE REC'D BY LOCAL REG July 29, 1949		REGISTRAR'S SIGNATURE 420 Charlotte McDowell	
25. FUNERAL DIRECTOR'S SIGNATURE J. M. Zerkes		ADDRESS Mulberry, Kas	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD 6000

RECEIVED AUG 3 1949

District Health Office No. 6,

District File Number 849-90²

Date Filed 8-3-49

AUG 17 1949

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 _____
Student Embalmer

Signed J. M. Berkey

Licensed Embalmer No. 2326

P. O. Address Mulberry Knoss

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 this body is not embalmed, fact should be so stated above.