

FILED MAY 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16225

State File No.

BIRTH NO. _____ REG. DIST. NO. 124 PRIMARY REG. DIST. NO. 2000 Registrar's No. 457

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Webster	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Rogersville	
c. LENGTH OF STAY (in this place) 15 minutes		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION OZARK OSTEOPATHIC HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) Keturah	b. (Middle) —	c. (Last) Swearengin	4. DATE OF DEATH (Month) (Day) (Year) May 20, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 26, 1869	9. AGE (In years last birthday) 82	10. UNDER 1 YEAR Months 1 Days 24	11. UNDER 1 HR. Hours — Mins. —
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Douglas County	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Joshua Stillings	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Widow
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME E. K. Swearengin, Rogersville, Mo.	ADDRESS Rogersville, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Failure		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombotic Encephalomalacia with cerebral hemorrhage		
	DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May 20, 1951, to May 20, 1951, that I last saw the deceased alive on May 20, 1951, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE Deland E. White (Degree or title) DO	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 5/20/51
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24a. BURIAL, CREMATION, REMOVAL Cremated	24b. DATE May 22-51	24c. NAME OF CEMETERY OR CREMATORY Swearengin Cemetery Douglas County Mo	24d. LOCATION (City, town, or county) (State) 710
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DATE RECD BY LOCAL REG. 5-21-51	REGISTRAR'S SIGNATURE W. E. Hendley 450	25. FEDERAL DIRECTOR'S SIGNATURE T. B. Chaffin, Ozark, Mo.
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EXHIBIT 1

EXHIBIT 2

STATEMENT BY LICENSED EMBALMER

EXHIBIT 3

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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 this body is not embalmed, fact should be so stated above.