

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27863**
Registrar's No. **88**

FILED SEP 12 1951

BIRTH NO. _____ REG. DIST. NO. **278** PRIMARY REG. DIST. NO. **3054**

1. PLACE OF DEATH a. COUNTY Pike 0821		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pike	
b. CITY OR TOWN Louisiana		c. CITY OR TOWN Ashburn 0820	
c. LENGTH OF STAY (in this place) 9 Days		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pike County Hospital			

3. NAME OF DECEASED (Type or Print) Charles	a. (First)	Hiram	b. (Middle)	Swisher	c. (Last)	4. DATE OF DEATH August 28, 1951	(Month) (Day) (Year)
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 12, 1874	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Fireman	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Fireman	10b. KIND OF BUSINESS OR INDUSTRY City Fire Dept.	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Hiram Swisher	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Laura Maralida Swisher
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Laura Swisher, Ashburn, Missouri	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis, Hypertensive, Cardiovascular Disease with terminal uremia and Bronchopneumonia		
	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? 443X 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **8-18, 1951**, to **8-24, 1951**, that I last saw the deceased alive on **8-24, 1951**, and that death occurred at **8:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Chas. H. Levelle (Degree or title) M.D.	23b. ADDRESS Louisiana, Missouri	23c. DATE SIGNED 9-1-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 31, 1951	24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	24d. LOCATION (City, town, or county) (State) Louisiana, Missouri
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DATE REC'D BY LOCAL REG. Sept 1, 1951	REGISTRAR'S SIGNATURE Vernice Collier	374	25. FUNERAL DIRECTOR'S SIGNATURE Haley Mortuary, Louisiana, Mo	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Received: **SEP 10 1951**
DISTRICT HEALTH OFFICE #2
District File Number *9-57-1609*
Date Filed: **SEP 11 1951**

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.