

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9490**
Registrar's No. **261**

FILED MAR 16 1953

BIRTH NO. **8103** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

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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) Seymour, Rural 1120	
d. FULL NAME OF HOSPITAL OR INSTITUTION OZARK OSTEOPATHIC HOSPITAL		d. STREET ADDRESS (If rural, give location) Rt. # 4	

3. NAME OF DECEASED (Type or Print) a. (First) (Female) b. (Middle) Infant) c. (Last) Swearengin	4. DATE OF DEATH (Month) (Day) (Year) March 11, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 11, 1953	9. AGE (In years last birthday) IF UNDER 1 YEAR 17 Months 27 Days	IF UNDER 1 YEAR Hour 17 Min 27
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) xxxxxxx	10b. KIND OF BUSINESS OR INDUSTRY xxxxxxx	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Floyd Swearengin	13b. MOTHER'S MAIDEN NAME Bernice Irene Lucas	14. NAME OF HUSBAND OR WIFE XXXXXXXXXXXX
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. xxxxxx	17. INFORMANT'S SIGNATURE OR NAME Floyd Swearengin, Seymour, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature		DUE TO (b) Eclampsia of mother		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7695		

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3/11**, 19**53**, to **3/11**, 19**53**, that I last saw the deceased alive on **3/11**, 19**53**, and that death occurred at **7:10 pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William D. Helge, M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED Mar 11 1953
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-12-53	24c. NAME OF CEMETERY OR CREMATORY Union Chapel Cem.	24d. LOCATION (City, town, or county) (State) Webster Co. Mo.
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DATE REC'D BY LOCAL REG. 3-14-53	REGISTRAR'S SIGNATURE William Swearengin	25. FUNERAL DIRECTOR'S SIGNATURE W. K. Swell	ADDRESS Fordland, Mo.
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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
Student Embalmer

No Embalming
Signed _____

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.