No. 300
10.48

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

FILED JUN 28 1954

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 18643

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 573-A

**1. PLACE OF DEATH**
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
c. LENGTH OF STAY (In this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 830 West Scott

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Greene
c. CITY OR TOWN: Springfield
d. Is Residence within limits of a city or incorporated town? Yes [X] No [ ]
e. STREET ADDRESS (If rural, give location): 830 West Scott 0296

**3. NAME OF DECEASED** (Type or Print)
a. (First): Marie
b. (Middle): Burns
c. (Last): Swanson

**4. DATE OF DEATH** (Month) June (Day) 15 (Year) 1954

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married
**8. DATE OF BIRTH**: Dec 6, 1899
**9. AGE** (In years last birthday): 54 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home
**11. BIRTHPLACE** (City and State or Foreign Country): Shawnee, Oklahoma
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Walter Burns
**13b. MOTHER'S MAIDEN NAME**: Lucy Siveon
**14. NAME OF HUSBAND OR WIFE**: Charles O Swanson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no (If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S SIGNATURE OR NAME**: Charles O. Swanson, Springfield, Mo. ADDRESS

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Tumor of Brain, Malignant Glioblastoma — INTERVAL BETWEEN ONSET AND DEATH: 2.5 yrs.

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**: 8-7-53
**19b. MAJOR FINDINGS OF OPERATION**: Large tumor (August 7, 1953 operation) 195X
**20. AUTOPSY?** YES [ ] NO [X]

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* June, 1953, *to* June 15, 1954, *that I last saw the deceased alive on* June 15, 1954 *and that death occurred at* 8:00P *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Leo W. Farthing M.D.
**23b. ADDRESS**: 808 Med Arts - Spfd. Mo
**23c. DATE SIGNED**: June 18, 54

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: June 19, 1954
**24c. NAME OF CEMETERY OR CREMATORY**: Eastlawn Cemetery
**24d. LOCATION** (City, town, or county) (State): Springfield, Missouri

DATE REC'D BY LOCAL REG.: 6-21-54
REGISTRAR'S SIGNATURE: Faith Williamson
**25. FUNERAL DIRECTOR'S SIGNATURE**: Alma Lohmeyer
ADDRESS: Springfield Mo.

(Licensed Embalmer's Statement on Reverse Side)

Gene Farthing
Med. Arts Bul
175

JUL 7 19

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Gene C. Hunter

Licensed Embalmer No. 4739

P. O. Address Springfi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai 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.