

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23933

State File No. ....

FILED AUG 2 - 1954

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>290</u>			
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>				b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>			c. LENGTH OF STAY (in this place) <u>12 days</u>	c. CITY OR TOWN <u>Sedalia</u>		d. Is Residence within limits of a city or incorporating town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Rural Route 5</u>				<u>0 800/</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u>			a. (First)	b. (Middle) <u>F.</u>	c. (Last) <u>SWERNGIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 23, 1954</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 3, 1884</u>		9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months	IF UNDER 6 MRS. Days	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Near Warsaw, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jasper Swerngin</u>			13b. MOTHER'S MAIDEN NAME <u>Phoebe Dillon</u>			14. NAME OF HUSBAND OR WIFE <u>Lillian Wear Swerngin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lillian Swerngin, Sedalia, Mo.</u>					
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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>  <u>?</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) <u>Sedalia Mo</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 <u>July 13, 1954</u> , to <u>July 23, 1954</u> , that I last saw the deceased alive on <u>July 23, 1954</u> , and that death occurred at <u>7:00 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>A. L. Walter MD</u>				23b. ADDRESS <u>Sedalia Mo</u>			23c. DATE SIGNED <u>July 26, 54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7/26/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>					
DATE REC'D BY LOCAL REG. <u>AUG-2 1954</u>	REGISTRAR'S SIGNATURE <u>Blayne A. Bridges</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Deekart Sedalia, Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

GILLESPIE FUNERAL HOME

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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.....  
Signature of Student Embalmer

Signed *Russell C. Maa*

Licensed Embalmer No. *488*

P. O. Address *Sedalia*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.