

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. T. MacDonell
State File No. 10599
Registrar's No. 1138-A

FILED JAN 3 1955

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

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) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN MARSHFIELD
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE Hospital		e. STREET ADDRESS (If rural, give location) 1129	

3. NAME OF DECEASED (Type or Print) a. (First) HATTIE b. (Middle) ELIZABETH c. (Last) CAUGHRAN			4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH JANUARY 25, 1885	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Douglas Co., Missouri	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Wm R. Swearingin	13b. MOTHER'S MAIDEN NAME MARTHA TROTTER	14. NAME OF HUSBAND OR WIFE Deceased
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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. 486-24-0458	17. INFORMANT'S SIGNATURE OR NAME Robert Coughran	ADDRESS Kansas City, 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) Arteriosclerotic heart disease with ventricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES with ventricular fibrillation		
		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	19b. MAJOR FINDINGS OF OPERATION 4200	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 **Dec. 6, 1954**, to **Dec. 7, 1954**, that I last saw the deceased alive on **Dec. 7, 1954**, and that death occurred at **7:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Marjorie P. Simon, MD	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 12-23-54
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 12-20-54	24c. NAME OF CEMETERY OR CREMATORY Marshfield Cemetery	24d. LOCATION (City, town, or county) (State) Marshfield, Mo.
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DATE REC'D BY LOCAL REG. 12-27-54	REGISTRAR'S SIGNATURE Cliff Williams	25. FUNERAL DIRECTOR'S SIGNATURE R. W. Barber	ADDRESS Marshfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Levin T. Sandley*.....

Licensed Embalmer No. *4815*.....

P. O. Address *Meriden*.....

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.