

FILED MAR 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7932

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 136 PRIMARY REG. DIST. NO. 4211 Registrar's No. ....

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARRISON</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MO</u> b. COUNTY <u>HARRISON</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give town)<br><u>Eagleville</u> | c. LENGTH OF STAY (in this place township)<br><u>10 yrs</u> | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>Eagleville</u> <u>0410</u>                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Home</u>                                |   | d. STREET ADDRESS (If rural, give location)<br><u>NONE</u>   |  |

|   |   |
|---|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>UNICE</u> b. (Middle) <u>EMMA</u> c. (Last) <u>SWIGART</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>MARCH 9, 1955</u> |
|---|---|

|                      |                               |  |  |  |
|----------------------|-------------------------------|--|--|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u> | 8. DATE OF BIRTH<br><u>Dec. 30, 1881</u> | 9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>0</u> Min. |
|----------------------|-------------------------------|--|--|--|

|   |  |   |   |
|---|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housekeeping</u> | 11. BIRTHPLACE (State or foreign country)<br><u>HARRISON Co. Mo</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u> |
|---|--|---|---|

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|--|---|---|
| 13a. FATHER'S NAME<br><u>Jacob Hon</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Martha Brooks</u> | 14. NAME OF HUSBAND OR WIFE<br><u>John W. Swigart</u> |
|--|---|---|

|  |                                      |   |         |
|--|--------------------------------------|---|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u> | 16. SOCIAL SECURITY NO.<br><u>no</u> | 17. INFORMANT'S SIGNATURE OR NAME<br><u>John W. Swigart</u> | ADDRESS |
|--|--------------------------------------|---|---------|

|   |  |               |                                  |
|---|--|---------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |               | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic Pulmonary Carcinoma</u>   |               | <u>1 mo</u>                      |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Primary Adeno Carcinoma Uterus</u><br>DUE TO (c) |               | <u>5 years</u>                   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Metastatic Carcinoma Lumbar Spine, Pelvic</u>   |  | <u>1 YEAR</u> |                                  |

|                                    |  |   |
|------------------------------------|--|---|
| 19a. DATE OF OPERATION<br><u>-</u> | 19b. MAJOR FINDINGS OF OPERATION<br><u>-</u> | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------------|--|---|

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|---|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>-</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><u>-</u> |
|---|--|---|

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|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.<br><u>-</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><u>-</u> |
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22. I hereby certify that I attended the deceased from Sept 20, 1950, to March 9, 1955, that I last saw the deceased alive on March 7, 1955, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title)<br><u>Wm C Courtney</u> <u>D.O.</u> | 23b. ADDRESS<br><u>BETHANY - Missouri</u> | 23c. DATE SIGNED<br><u>3/11/55</u> |
|--|---|------------------------------------|

|  |                                |   |   |
|--|--------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 24b. DATE<br><u>Mar 11, 55</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Masonic Cemetery</u> | 24d. LOCATION (City, town, or county) (State)<br><u>Eagleville MO</u> |
|--|--------------------------------|---|---|

|  |  |       |  |                                  |
|--|--|-------|--|----------------------------------|
| DATE REC'D BY LOCAL REG.<br><u>3-23-55</u> | REGISTRAR'S SIGNATURE<br><u>Florence C. Powell</u> | 449-0 | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Merald W. Boggs</u> | ADDRESS<br><u>Eagleville, Mo</u> |
|--|--|-------|--|----------------------------------|

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 .....  
Student Embalmer

Signed Gerald W. Bogen

Licensed Embalmer No. 4762

P. O. Address Eagleville, Mo

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.