

FILED SEP 13 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26788

|  |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|---|--|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>170</u>  |  | PRIMARY REG. DIST. NO. <u>3033</u>   |   | Registrar's No. <u>145</u>   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>LACLEDE</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> |   |  |  | b. COUNTY <u>LACLEDE</u>  |  |
| b. CITY (If outside corporate limits, write RURAL and give town(ship))<br>OR TOWN <u>LEBANON</u>   |  |  | c. LENGTH OF STAY (In this place)<br><u>14 HOURS</u> |  | c. CITY OR TOWN <u>OAKLAND</u>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>WALLACE HOSPITAL</u>  |  |  |  | STREET ADDRESS (If rural, give location)<br><u>RURAL LEBANON T.S.</u>  |   |  |  | <u>C-530</u>  |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>AGNES</u>   |  |  | b. (Middle) <u>ELIZEBETH</u>                         |  | c. (Last) <u>SWEITZER</u>   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>SEPT. 3, 1955</u>  |   |  |
| 5. SEX <u>FEMALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>  |   | 8. DATE OF BIRTH <u>JULY 13, 1876</u>                                |  | 9. AGE (In years last birthday) <u>79</u>   |  |
| IF UNDER 1 YEAR Months   |  | IF UNDER 1 YEAR Days   |  | IF UNDER 24 HRS. Hours   |   | Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work depending most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>DOMESTIC</u> |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>MELTON IA.</u>         |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                       |  |
| 13a. FATHER'S NAME<br><u>GEORGE T. SAMPLE</u>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><u>JANE BURNS</u>       |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>LEANORD SWEITZER</u>               |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)<br><u>NO.</u>  |  |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>               |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>MR. RAY BROWN, LEBANON, MO.</u> |  |  |   |  |
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) <u>331X</u><br><br>DUE TO (c)<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u>                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  |  |   |  |  | 20. AUTOPSY?<br>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)                                 |  |  |   |  |
| 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>June</u> , 19 <u>46</u> to <u>Sept 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 3</u> , 19 <u>55</u> , and that death occurred at <u>6:30A</u> m., from the causes and on the date stated above. |  |  |  |  |   |  |  |   |  |
| 23a. SIGNATURE (Degree or title)<br><u>Taul A Jenkins M.D.</u>   |  |  |  | 23b. ADDRESS<br><u>Knight Bldg Lebanon Mo</u>  |   |  | 23c. DATE SIGNED<br><u>9-3-55</u>  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24b. DATE<br><u>9-5-55</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>OAKLAND CEMETERY</u>  |   | 24d. LOCATION (City, town, or county) (State)<br><u>OAKLAND, Mo.</u> |  |   |  |
| DATE REC'D BY LOCAL REG.<br><u>9-5-1955</u>  |  | REGISTRAR'S SIGNATURE<br><u>Hella L. May</u>   |  |  | 424 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>J.P. Palmer</u>                      |  | ADDRESS<br><u>Lebanon, Mo.</u>   |   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

32  
03.000  
0.48

Received 9-12-55  
Laclede County Health Unit  
File No. 145  
Date Filed 9-12-55

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 Stanleigh B. Palm

Licensed Embalmer No. 48  
P. O. Address Lebons

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.