

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3126

STATE FILE NUMBER

FILED FEB 4 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **478**

Health, Welfare, Public Service
300
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be noted.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Bernie	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 31	
3. NAME OF DECEASED (Type or print) HOWARD SWAFFORD		4. DATE OF DEATH 1-14-57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 79
11. BIRTHPLACE (City and state or country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
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. none	
17. INFORMANT Jessie Swafford, Los Angeles, Calif		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 24 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ASCENDING CHOLANGITIS			1 WEEK
DUE TO (c) CARCINOMA OF PANCREAS			8 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 12-17-56 to 1-14-57 and last saw her/him alive on 1-14-57 Death occurred at 1³⁰ P 1 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lester J. Nathan M.D.		22b. ADDRESS 216 Smith Langleyway	
22c. DATE SIGNED 1-16-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1-15-57	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Bernie, Mo.	
24. FUNERAL DIRECTOR ADDRESS Duffie, Bernie, Mo.		25. DATE RECD. BY LOCAL REG. JAN 16 '57	
		26. REGISTRAR'S SIGNATURE Pearl Smith M.D.	

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 *Harvey Kable*

Licensed Embalmer No. 45

P. O. Address *St. Louis*

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