

FILED AUG 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27865**

BIRTH NO. _____ REG. DIST. NO. **82** PRIMARY REG. DIST. NO. **3017** Registrar's No. **98**

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boonville		c. LENGTH OF STAY (in this place) Life	c. CITY OR TOWN Boonville
d. FULL NAME OF HOSPITAL OR INSTITUTION At home, 105 Sixth St.		STREET ADDRESS (If rural, give location) 105 Sixth St.	
3. NAME OF DECEASED (Type or Print) a. (First) Angus		b. (Middle)	c. (Last) Swap
4. DATE OF DEATH (Month) (Day) (Year) Aug 8 57		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	
8. DATE OF BIRTH June 2ⁿ 1890		9. AGE (In years last birthday) 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Own shop	
11. BIRTHPLACE (City and State or Foreign Country) Boonville, Missouri.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Frank Swap.		13b. MOTHER'S MAIDEN NAME Janie MacKenzie	
14. NAME OF HUSBAND OR WIFE ???		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Miss Helen Swap, Boonville, Mo.	
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) Coronary Occlusion ANTECEDENT CAUSES DUE TO (b) Had been dead two or three days when found 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 _____	
20. AUTOPSY? 2 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) 4201	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 no attendant , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE Dr. Hooper G.R. (Degree or title)		23b. ADDRESS Boonville Mo	
23c. DATE SIGNED 8/10/57		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Aug. 11, 1957		24c. NAME OF CEMETERY OR CREMATORY Walnut Grove	
24d. LOCATION (City, town, or county) (State) Boonville, Missouri.		25. FUNERAL DIRECTOR'S SIGNATURE Goodman & Boller, Boonville, Mo.	
DATE REC'D BY LOCAL REG. 8-10-57		REGISTRAR'S SIGNATURE Dr. Hooper	

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

SEP 18 1957

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 *William W. Wood*

Licensed Embalmer No. 4539

P. O. Address Boonville,

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.