

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40097

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3523 Registrar's No. 638

1. PLACE OF DEATH a. COUNTY <u>Henry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>806 N Washington</u>		Length of stay in lb <u>72 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>806 N Washington</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DARCUS</u> Middle <u>EVELYN</u> Last <u>SWEATE</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25 1862</u>	9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u> Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (One kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTH PLACE (City and state or country) <u>Leland Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Ben. Shockley</u>			14. MOTHER'S MAIDEN NAME <u>Fannie Shockley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT Address <u>Alice Fewell Clinton Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
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 <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a. m. <u>-</u> p. m. <u>-</u>					
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 <u>9-1-55</u> to <u>10-9-57</u> and last saw her alive on <u>9-24-57</u> Death occurred at <u>12:25 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>R. E. Harbaugh, D.O.</u>		22b. ADDRESS <u>Clinton, Mo.</u>	22c. DATE SIGNED <u>11-11-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/13/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Antioch</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton Missouri</u>		
24. FUNERAL DIRECTOR <u>SCHABERG FUNERAL HOME</u>		25. DATE RECD. BY LOCAL REG. <u>11-12-57</u>	26. REGISTRAR'S SIGNATURE <u>Willeded Bigum</u>		
214 SO. SECOND PH 454 Clinton Mo (Licensed Embalmer's Statement on Reverse Side)					

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..... *F. L. Schaefer*

Licensed Embalmer No. *451*

P. O. Address *Clinton*

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.