

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022221

STATE FILE NUMBER

FILED JUN 25 1958

Registration District No.

146

Primary Registration District No.

53-68

Registrar's No.

260

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Blue Twp		c. CITY OR TOWN Kansas City	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8730 Lexington		Length of stay in 1b	
1000 ^d STREET ADDRESS 8730 Lexington		(If outside, give location)	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrude Middle Swanner Last Swanner			4. DATE OF DEATH Month 6 Day 13 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894 August 28
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months 6 Days 13	IF UNDER 24 HRS. Hours 13 Min. 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Oneida Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Wylie Thornton Stidham		13b. MOTHER'S MAIDEN NAME Opie Moses	
14. NAME OF HUSBAND OR WIFE Walter S. Swanner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Walter S. Swanner		Address 4346 Monroe K.C.Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Esophagus			INTERVAL BETWEEN ONSET AND DEATH 6 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 type="checkbox"/> NO <input checked="" 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.) 150X	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 Feb 1958 to June 13th and last saw her alive on June 13-1958 Death occurred at 4:00 P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. Salvin W. Teakins D.O.		22b. ADDRESS 8218 Wunner Rd Kc Mo	
22c. DATE SIGNED 6/14/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-16-1958	
23c. NAME OF CEMETERY OR CREMATORY Floral Hills Mem. Gardens K.C. Mo.		23d. LOCATION (City, town, or county) (State) K.C. Mo.	
24. FUNERAL DIRECTOR Floral Hills Mem. Chapels. K.C. Mo.		25. DATE RECD. BY LOCAL REG. 6-16-58	
26. REGISTRAR'S SIGNATURE James S. King			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Handwritten notes:
205-05-01
P. O. Address
D. O.

JUN 24 1958

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 *R. M. Fungler*

Licensed Embalmer No. *3938*
P. O. Address *N.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.