

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029760
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 240 Primary Registration District No. 5826 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LaFont Twsp.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Conran</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Conran</u>		d. STREET ADDRESS (If outside, give location) <u>Conran</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Mae</u> Last <u>Swilley</u>			4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1894</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>26</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>New Madrid Co., Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13. FATHER'S NAME <u>Kibble Swilley</u>		14. MOTHER'S MAIDEN NAME <u>Louise Davis</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>None</u>	
17. INFORMANT <u>Mack Swilley-Conran, Mo.</u>		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) <u>uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>nephrosis</u>			
DUE TO (c) <u>591X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			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.)		
20c. TIME OF INJURY Hour <u></u> Month, Day, Year 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 3-7-54 to 8-1-58 and last saw ^{her}him alive on 8-1-58
Death occurred at 5:50 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>James O. Cameron D.O.</u>	(Degree or title)	22b. ADDRESS <u>2 Blomfield, Missouri</u>	22c. DATE SIGNED <u>8-9-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park</u>	23d. LOCATION (City, town, or county) (State) <u>Near Lilbourn, Mo.</u>

24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-11-58</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Ponder Deputy</u>
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(Licensed Embalmer's Statement on Reverse Side)

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56

Health,
Welfare
Public
Service

AUG 23 1958

DATE RECEIVED AUG 13 1958
NEW MADRID CO. HEALTH CENTER.



P. J. L.

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 *Harold H. Ponder*.....

Licensed Embalmer No. 505

P. O. Address *Lilbourn, Mo.*

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.