

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033034

STATE FILE NUMBER

FILED SEP 16 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4141

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Brookfield, Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF DECEASED (If NOT in hospital, give location) <u>St. Marys Hosp.</u> Length of stay in lb <u>1 wk.</u>		d. STREET ADDRESS <u>416 Mason</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>A.</u> Last <u>Swike</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1893</u>		
9. AGE (In years last birthday) <u>65</u> UNDER 1 YEAR Months <u>5</u> Days <u>6</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>House wife</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City, Kans</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Phillip Struening</u>			
13b. MOTHER'S MAIDEN NAME <u>Pauline Anklauer</u>		14. NAME OF HUSBAND OR WIFE <u>Edward L. Swike</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Edward L. Swike - Brookfield 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>Cardiac failure due to cardiac burden of tachycardia due to PORTAL AND MESENTERIC VEIN THROMBOSIS FOLLOWING SPLENECTOMY FOR SPLENOMEGALY</u> DUE TO (b) <u>MEGAKARYCYTOSIS (AGNOGENIC MYELOID METAPLASIA)</u> DUE TO (c) <u>MEGAKARYCYTOSIS (AGNOGENIC MYELOID METAPLASIA)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (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.) <u>SAFI</u>			
20c. TIME OF INJURY Hour <u>3:15</u> Month, Day, Year <u>pm</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 <u>Brookfield</u> COUNTY <u>MO</u> STATE <u>MO</u>			
21. I attended the deceased from <u>8-19-58</u> to <u>8-27-58</u> and last saw her alive on <u>8-27-58</u> Death occurred at <u>3:15 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or title) <u>George O. Miles, M.D.</u>		22b. ADDRESS <u>4706 Broadway K.C. MO</u>			
22c. DATE SIGNED <u>8-28-58</u>		23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>			
23b. DATE <u>Aug 28-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>			
23d. LOCATION (City, town, or county) <u>Brookfield, Mo</u>		23e. (State)			
24. FUNERAL DIRECTOR <u>Hill Funeral Home</u> ADDRESS <u>Brookfield</u>		25. DATE RECD. BY LOCAL REG. <u>8-29-58</u>			
26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>					

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
George O. Miles



MAR 25 1965

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 *Walter L. Kasper*

Licensed Embalmer No. *4225*

P. O. Address *Raytown, 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.