

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20-000355

STATE FILE NUMBER

FILED FEB 2 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 109

300  
-57 2

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Joseph</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>KC Mo</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital #2</i>	Length of stay in lb <i>2 mos 14 days</i>	d. STREET ADDRESS (If outside, give location) <i>3210 Charlotte</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Hannah</i> Middle <i>G</i> Last <i>Swope</i>			4. DATE OF DEATH Month <i>1</i> Day <i>27</i> Year <i>59</i>		
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 20, 1873</i>	9. AGE (In years last birthday) <i>85</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house work</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTH PLACE (City and state or country) <i>K.C. Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
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13a. FATHER'S NAME <i>John Babcock</i>	13b. MOTHER'S MAIDEN NAME <i>Adeline Gooding</i>	14. NAME OF HUSBAND OR WIFE <i>J.W. Swope, Sr.</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>J.W. Swope</i>	Address <i>3210 Charlotte KC Mo</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i> <i>18 years</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>arteriosclerosis</i>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4221</i>		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 _____ a.m. _____ p.m.	Month, Day, Year _____

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 _____
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21. I attended the deceased from *1-27-1959* to *1-27-1959* and last saw her/him alive on *1-27-1959*  
Death occurred at *11:15 a* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>G.E. Gossins M.D.</i>	22b. ADDRESS <i>State Hospital #2</i>	22c. DATE SIGNED <i>1-27-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-30-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Mariah Cem</i>	23d. LOCATION (City, town, or county) (State) <i>Kan City Mo</i>
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24. FUNERAL DIRECTOR <i>Melody McCully Embler</i>	ADDRESS <i>Kan City Mo</i>	25. DATE RECD. BY LOCAL REG. <i>Jan 28, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>
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All diseases in Part I must be causally related.  
D. C. E. GOSSINS

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Melvin Banton* .....

Licensed Embalmer No. *4903* .....

P. O. Address *K. E. ...* .....

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.