THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005914

STATE FILE NUMBER 893

FILED MAR 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY OR TOWN KANSAS CITY — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSPITAL — Length of stay in Hospital 39 YEARS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 5110 GARFIELD AVENUE — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First JOHN Middle ROSCOE Last SWISHER

4. DATE OF DEATH Month FEBRUARY Day 13 Year 1959

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH JANUARY 23, 1885
9. AGE (In years at last birthday) 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BUILDER
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (City and state or country) POWHATTAN, KANSAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME WILLIAM THOMAS SWISHER
13b. MOTHER'S MAIDEN NAME MARTHA KENNEDY
14. NAME OF HUSBAND OR WIFE AGNES C. SWISHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 496-03-2969
17. INFORMANT MRS. AGNES C. SWISHER Address 5110 GARFIELD AVE. KANSAS CITY, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
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 [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 13, 1959, to Feb 13, 1959 and last saw ~~her~~ him alive on Feb 13, 1959
Death occurred at 1:05 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Martin P. Hunter M.D. (Degree or title)
22b. ADDRESS 1408 Waldheim Bldg.
22c. DATE SIGNED 2-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE FEB. 16, 1959
23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY
23d. LOCATION (City, town, or county) KANSAS CITY (State) MISSOURI

24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.
25. DATE RECD. BY LOCAL REG. 2-16-59
26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Martin P. Hunter

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 .....

Licensed Embalmer No.....

P. O. Address.....

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.