

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032872

FILED VS. OCT 13 1959/64

Registration District No. Primary Registration District No. 3032 Registrar's No. 131

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg,</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Warrensburg,</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>Warrensburg Medical Center,</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>611 Grover Street,</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>INFANT SWISHER</u>				4. DATE OF DEATH Month Day Year <u>October 8th, 1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-8-59</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (City and state or country) <u>Warrensburg, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>James Swisher</u>			13b. MOTHER'S MAIDEN NAME <u>Marian Meyer Toedtman</u>		14. NAME OF HUSBAND OR WIFE <u>Single</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 Address <u>Mr. James Swisher, Warrensburg, Mo.</u>				
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>2-lobules lived</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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	
21. I attended the deceased from <u>10-8-59</u> to <u>10-8-59</u> and last saw her <u>alive</u> on <u>10-8-59</u> Death occurred at <u>5:05 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>J. K. Maxson M.D.</u>				22b. ADDRESS <u>Warrensburg, Missouri</u>		22c. DATE SIGNED <u>10-8-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-9-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laural Oak,</u>		23d. LOCATION (City, town, or county) <u>Windsor, Missouri</u>		23e. (State)		
24. FUNERAL DIRECTOR ADDRESS <u>Huston Funeral Home, Windsor, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>Oct. 9, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Lavonne B. Cuthrell</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert F. McDonald

Licensed Embalmer No. 4825

P. O. Address Wilmington

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.