

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-035127
STATE FILE NUMBER

FILED VS NOV 10 1959

Registration District No. 14 Primary Registration District No. 4028 Registrar's No. 14

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Barton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Barton</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberal</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Liberal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b		d. STREET ADDRESS <u>0060</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>May</u> Last <u>Swartz</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>1</u> Year <u>1959</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 type="checkbox"/>		8. DATE OF BIRTH <u>July 28 1892</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Arma Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Milt Siple</u>			13b. MOTHER'S MAIDEN NAME <u>Melissa Dawson</u>			14. NAME OF HUSBAND OR WIFE <u>Jess H. Swartz</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>Jess Swartz Liberal 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>Circulatory Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute Coronary Thrombosis 260x</u>							<u>30 hrs.</u>	
DUE TO (c) <u>Diabetes Mellitus & Arteriosclerosis</u>							<u>2 yrs.</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity and Diabetes Mellitus began 3 to 5 yrs. ago</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 _____ a.m. _____ p.m.								
20d. INJURY OCCURRED WHILE AT <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>JUNE 27, 1947</u> to <u>Nov. 1, 1959</u> and last saw her <u>alive</u> on <u>Oct. 31, 1959</u> . Death occurred at <u>1:55 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Doctor or title) <u>Munroe Kneeland, D.O.</u>				22b. ADDRESS <u>Liberal, Missouri</u>		22c. DATE SIGNED <u>Nov 2 '59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov. 3 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MM. Olive Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pittsburg Kansas</u>			
24. FUNERAL DIRECTOR <u>Beany Funeral Home Sheldon</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Nov 2, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte McDowell</u>		

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 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

420-0

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 *J. Bernard Perry*

Licensed Embalmer No. *4161*

P. O. Address *Sheldon 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.