

# JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043028

FILED VS. NOV 3 0 1959 33

Primary Registration District No. 3074

Registrar's No. 212

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>SCOTT</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>SCOTT</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		Length of stay in 1b <u>2 1/2 mos.</u>	c. CITY OR TOWN <u>SIKESTON</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 <u>SHOFFITT NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>901 SIKES AVE.</u>		Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>ARTHUR WALTER SWACKER</u>			<b>4. DATE OF DEATH</b> Nov. 11, 1959		
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>CAUCASIAN</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-28-1896</u>	<b>9. AGE (last birthday)</b> <u>73</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RET. Hwy DEPT. Employee</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>AGENT</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Louis, Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
<b>13a. FATHER'S NAME</b> <u>No RECORD</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>No RECORD</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>ESTELLE ARENSMEYER (DECD)</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) If yes, give year or dates of service) <u>YES</u> <u>NAVY</u>		<b>16. SOCIAL SECURITY NO.</b> <u>489-09-9144</u>		<b>17. INFORMANT</b> Address <u>401 MALCOLM SIKESTON, MO.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH <u>2-5 hours</u>
IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Hypertension - essential</u>					
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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <u>11-9-59</u> to <u>11-10-59</u> and last saw her/him alive on <u>11-10-59</u> Death occurred at <u>2:50 P.M.</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> <u>E.D. Urban, M.D.</u> (Degree or title)			<b>22b. ADDRESS</b> <u>SiKeston</u>		<b>22c. DATE SIGNED</b> <u>11-16-59</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE</b> <u>11-13-1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GARDEN OF MEMORIES</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>SIKESTON, Mo.</u>
<b>24. FUNERAL DIRECTOR</b> <u>Funellee R. Hunter</u> ADDRESS <u>SIKESTON, Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-17-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. Ella Hunter</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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Edward E. Munnala

Licensed Embalmer No. 4164

P. O. Address Sikeston, 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.