

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010754

FILED VS APR 4 1960 142

Registration District No. Primary Registration District No. 1006 Registrar's No. 22

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howell</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Goldsberry</u> Length of stay in lb c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Howell</u> c. CITY OR TOWN <u>Mountain View</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>John Sibert Swenk</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>March 23, 1960</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/14/77</u>	<b>9. AGE (last birthday)</b> <u>83</u>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Minister</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Litchfield, Mich.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		
<b>13a. FATHER'S NAME</b> <u>John Swenk</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Ethel Swenk</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>395-32-7566</u>		<b>17. INFORMANT</b> Address <u>Ethel M. Swenk Mtn. View, Missouri</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting aneurysm - descending aorta</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>		
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 checked="" type="checkbox"/> NO <input 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"/> NOT WHILE AT WORK <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> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>3-6-59</u> to <u>3-23-60</u> and last saw <u>her</u> alive on <u>3-22-60</u> Death occurred at <u>6:40 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Dr. Jeffrey M.O.</u>			<b>22b. ADDRESS</b> <u>Mtn. View, Mo</u>		<b>22c. DATE SIGNED</b> <u>3-26-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>3/26/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>City Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Mountain View, Missouri</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>3-27-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Laura Mitchell</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 9 1960

**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

*Richard A. Norton*

Licensed Embalmer No. 5029

P. O. Address Mtn View

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.