URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-011271

FILED VS APR 4 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1618 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b 3½ Months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital
Inside Limits Yes ☒ No ☐

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 ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3614 ½ E. 60
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: INFANT Middle: KEVIN Last: MICHEAL SWISHER
4. DATE OF DEATH Month: March Day: 18, Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Nov. 28, 1959
9. AGE (last birthday) IF UNDER 1 YEAR: Months 3½ Days; IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (City and state or country): Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Clarence R. Swisher
13b. MOTHER'S MAIDEN NAME: Shirley Nisbett
14. NAME OF HUSBAND OR WIFE: none
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.: none
17. INFORMANT: Clarence Swisher, Address: 3614 ½ E. 60

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) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
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): Congenital Heart Disease (Trilocular)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 16 Mar. '60, to 18 Mar. '60 and last saw ~~her~~ him alive on 17 Mar. '60
Death occurred at 4:00 Am on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF William R. Doherty

22a. SIGNATURE (Degree or title) William R. Doherty, MD
22b. ADDRESS 2108 W. 75th KC Mo
22c. DATE SIGNED 18 Mar. '60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-21-60
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county) (State): Kansas City, Mo
24. FUNERAL DIRECTOR: Mellody-McGibley-Eylar Funeral Home ADDRESS: 1800 E. Linwood Blvd.
25. DATE RECD. BY LOCAL REG.: 3-18-60
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

Dr. [illegible]
2108 W. 25th
EN 2-2900

Fri - 1-5
Sat. - call first

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 James E. Hartle

Licensed Embalmer No. 4575

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.