

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034171

FILED VS OCT 13 1960

71

3012

94

STATE FILE NUMBER

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

INDEXED

1. PLACE OF DEATH a. COUNTY Clay				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Clay			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs		Length of stay in 1b 6 yrs.		c. CITY OR TOWN Excelsior Springs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Excelsior Springs Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 632 South Marietta			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Betty Middle June Last Schwenzer				4. DATE OF DEATH Month Sept. Day 16, Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1922	9. AGE (last birthday) 37	IF UNDER 1 YEAR Months 10 Days 7	IF UNDER 24 HR Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY XXXX		11. BIRTHPLACE (City and state or country) Richmond, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James W. Harrison			13b. MOTHER'S MAIDEN NAME Ellen Tarwater		14. NAME OF HUSBAND OR WIFE Harry F. Schwenzer (Dec)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 487-26-7438		17. INFORMANT Address James W. Harrison, 529 Park, Ex. Spgs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperpyrexia + Brain Damage						INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Viral Encephalitis						4 days	
DUE TO (c) Virus Infection - undetermined Type						4 days	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.	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 March 1957 to Sept 16, 1960 and last saw her Sept 16, 1960 alive on Sept 16, 1960 Death occurred at 4:00 PM. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (In ink or blue) Ralph L. Nicholson, M.D.				22b. ADDRESS Excelsior Springs, Mo		22c. DATE SIGNED 9/19/60	
23a. BURIAL, CREATION, REMOVAL (Specify) Burial	23b. DATE Sept. 19, 1960	23c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery		23d. LOCATION (City, town, or county) Excelsior Springs, MO.			
24. FUNERAL DIRECTOR ADDRESS Chas. Virgil Hoyle, Ex. Spgs. Mo.				25. DATE RECD. BY LOCAL REG. 9/20/60		26. REGISTRAR'S SIGNATURE Barclaine Hutchings	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

DEC 12 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 Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior

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.