

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024518
STATE FILE NUMBER

Registration District No. 74 Primary Registration District No. 5295 Registrar's No. 31
 AMENDED FILED AUG 14 1961

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Concord</u>		c. CITY OR TOWN <u>Lathrop</u>	
Length of stay in lb <u>1 week</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>Warren-Baumeier Nr. Home</u>		d. STREET ADDRESS (If outside, give location) <u>None</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Eelix</u> Last <u>Swindler</u>			4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1961</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-1881</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>25</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Humansville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Frank Swindler</u>	13b. MOTHER'S MAIDEN NAME <u>Eliza Raines</u>	14. NAME OF HUSBAND OR WIFE <u>Elta Jane Moller</u>
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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>Noval Swindler, Lathrop, Mo.</u>	Address
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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>General Inanition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 Mo's</u> <u>4 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized Carcinomatosis</u>	
	DUE TO (c) <u>Prostatic Carcinoma</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

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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year
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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 <u>Lathrop, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from 1958 to 1961 and last saw her alive on 8-7-61
 Death occurred at 12:25 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B. H. Waver</u>	22b. ADDRESS <u>Lathrop, Mo.</u>	22c. DATE SIGNED <u>8-8-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-9-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Alden Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dunnigan, Mo.</u>
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24. FUNERAL DIRECTOR <u>Morris D. Bailey</u>	ADDRESS <u>Lathrop, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-8-1961</u>	26. REGISTRAR'S SIGNATURE <u>Mary W. Scarce</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

AUG 24 1961

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 *Monie D. Gail*

Licensed Embalmer No. 41,117

P. O. Address *Fort Wayne, Ind.*

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.