MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-026511
STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 280

FILED JUL 26 1961

1. PLACE OF DEATH
a. COUNTY St Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre
Length of stay in 1b: 11 wks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Francois
c. CITY OR TOWN Flat River, Mo. Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 203 Third St Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Alonzo Middle: Swearingen Last:
4. DATE OF DEATH Month: July Day: 20 Year: 1961
5. SEX: male
6. COLOR OR RACE: White
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/10/89
9. AGE (last birthday): 72
IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist
10b. KIND OF BUSINESS OR INDUSTRY: lead mining
11. BIRTHPLACE (City and state or country): Iron County Mo
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: George Washington Swearingen
13b. MOTHER'S MAIDEN NAME: Mary Sherrill
14. NAME OF HUSBAND OR WIFE: Hazel Marie (Clanin)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Wife; 203 Third St; Flat River, Mo

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) Carcinoma of Prostate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chr Bronchitis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
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. ☐ 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 May 3 - 59, to July 20-61 and last saw ~~her~~ him alive on July 19-61
Death occurred at 3 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. H. Applberry (Degree or title) MD
22b. ADDRESS Rivermines Mo
22c. DATE SIGNED 7-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 7/23/61
23c. NAME OF CEMETERY OR CREMATORY: Parkview Cem.
23d. LOCATION (City, town, or county) (State): Farmington Mo.

24. FUNERAL DIRECTOR ADDRESS: Alvin W. Hood; Flat River, Mo.
25. DATE RECD. BY LOCAL REG.: July 21, 1961
26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

JUL 27 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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 2780

P. O. Address Flat River, M

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.