

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045631

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 85

AMENDED

FILED JAN 2 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Mississippi</u>		a. STATE <u>Missouri</u>	b. COUNTY <u>Mississippi</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston</u>		c. CITY OR TOWN <u>Charleston, Mo.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in lb <u>35 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>115 S. Grand</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>Henry</u> Middle <u>Douglas</u> Last <u>Switzer</u>			Month <u>Dec</u> Day <u>13</u> Year <u>1961</u>			
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>12/13/1879</u>	9. AGE (last birthday) <u>82</u>	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) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Canton, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Jacob Switzer</u>		13b. MOTHER'S MAIDEN NAME <u>Francis Baker</u>		14. NAME OF HUSBAND OR WIFE <u>Elena Hill Switzer</u>		
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. _____		17. INFORMANT <u>Clyde Switzer Charleston, Mo.</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>12/13/61</u> <u>3 yrs +</u>
IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u>	DUE TO (b) <u>A.S. heart disease</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>AV Block</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myocarditis</u>		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	
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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 checked="" 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 _____
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21. I attended the deceased from May 23/1960 to 12/13/61 and last saw ^{her}him alive on Nov 10 1961
Death occurred at 12/13/61 10:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>E. Charles Rawling MD</u>	22b. ADDRESS <u>Charleston Mo</u>	22c. DATE SIGNED <u>12/15/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>
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24. FUNERAL DIRECTOR <u>Mc Mickle, Charleston, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-15-61</u>	26. REGISTRAR'S SIGNATURE <u>Dorothy B. Haddock</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Elmer McAnally*

Licensed Embalmer No. 4695
P. O. Address Charleston 417

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.