

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-002052

164

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

AMENDED
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
L. BYRNE
SHOULD READ
ITEM NO.

FILED JAN 25 1962

1. PLACE OF DEATH
 a. COUNTY **JACKSON**
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **KANSAS CITY** Length of stay in lb **4 DAYS**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **ST. LUKE'S HOSPITAL** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **MISSOURI** COUNTY **JACKSON**
 c. CITY OR TOWN **INDEPENDENCE** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **615 GLENWOOD** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
EDWIN STANLEY SWAFFAR **JANUARY 11 1962**

5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **8/28/45** 9. AGE (last birthday) **16** 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) **STUDENT** 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) **CHICAGO, ILLINOIS** 12. CITIZEN OF WHAT COUNTRY **U. S. A.**

13a. FATHER'S NAME **ORNAN SWAFFAR** 13b. MOTHER'S MAIDEN NAME **ANNA M. METCALF** 14. NAME OF HUSBAND OR WIFE **----**

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. **NONE** 17. INFORMANT **ORNAN SWAFFAR** Address **5816 ASKEW AVE. KANSAS CITY, MO.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Polio cellulitis**
 DUE TO (b) **Typhlogenoous leukemia**
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 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 **6-20-1958** to **1-11-62** and last saw her alive on **1-10-62**
 Death occurred at **7:55 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) **R. Byrnes M.D.** 22b. ADDRESS **4635 Wyandotte, K.C. Mo** 22c. DATE SIGNED **1/11/62**

23a. BURIAL, CREMATION, REMOVAL (Specify) **REMOVAL** 23b. DATE **JAN. 13, '62** 23c. NAME OF CEMETERY OR CREMATOR **IRNHART CEMETERY** 23d. LOCATION (City, town, or county) **PURDY, MISSOURI**

24. FUNERAL DIRECTOR ADDRESS **D.W. NEWCOMER'S SONS 1331 BRUSH CR. KANSAS CITY, MO.** 25. DATE RECD. BY LOCAL REG. **1-11-62** 26. REGISTRAR'S SIGNATURE **Ruth Long**

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 Chester K Brown

Licensed Embalmer No. 4931

P. O. Address KE MD

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.