

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002053

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 749 Primary Registration District No. 1002 Registrar's No. 93

STATE FILE NUMBER

JAN 25 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>JACKSON</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>	a. STATE <u>KANSAS</u> b. COUNTY <u>WYANDOTTE</u>	c. CITY OR TOWN <u>KANSAS CITY</u>
Length of stay in 1b <u>4 1/2 yrs</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NORTH EAST REST HOME</u>		d. STREET ADDRESS (If outside, give location) <u>954 Sandusky</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <u>GERTRUDE</u>	Middle <u>SWEARINGEN</u>	Last	4. DATE OF DEATH	Month <u>JAN</u>	Day <u>3</u>	Year <u>1962</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>11-15-72</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours
				Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>CASTLEFORD ENGLAND</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>GEORGE HEPWORTH</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH EDWARDS</u>	14. NAME OF HUSBAND OR WIFE <u>BERTON SWEARINGEN</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>BERTON SWEARINGEN K.C. Mo.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>
IMMEDIATE CAUSE (a) <u>CEREBRAL Artery Thrombosis</u>	DUE TO (b) <u>CEREBRAL Artery Arteriosclerosis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

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
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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.)
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20c. TIME OF INJURY	Hour	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>Kansas City, Jackson Mo</u>	COUNTY	STATE
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21. I attended the deceased from Jan 1961 to Jan 1962 and last saw her alive Dec 1962
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. J. Shimmard</u> (Degree or title)	22b. ADDRESS <u>4006 St. John</u>	22c. DATE SIGNED <u>1-6-62</u>
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*23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>1-6-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO KANS</u>
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24. FUNERAL DIRECTOR <u>D.W. Newcomer</u> ADDRESS <u>San K.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-8-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 L. Shimmard
 SHOULD READ
 ITEM NO.

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 James T. DeWitt

Licensed Embalmer No. 4453

P. O. Address Kansas City

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.