

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017667

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 79

VS 300  
Rev. 4/59

10975

20970

3

4 1

5 0

6

7 0

8 2

9773.5

10

11

121-0

133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED APR 16 1962</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Saline</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		a. STATE <b>Missouri</b> COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>8 HRS.</b>		c. CITY OR TOWN <b>Malta Bend</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4 W NE Malta Bend</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LINDA KAY SWIGERT</b>		4. DATE OF DEATH Month Day Year <b>April 13, 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <b>4-13-1962</b>		9. AGE (last birthday) Months Days Hours Min. <b>8</b>		IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>X</b>		11. BIRTHPLACE (City and state or country) <b>Marshall, Mo</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Charles Swigert</b>		13b. MOTHER'S MAIDEN NAME <b>Frances Williams Swigert</b>	
14. NAME OF HUSBAND OR WIFE <b>xx</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>X X</b>		16. SOCIAL SECURITY NO. <b>X</b>	
17. INFORMANT <b>Charles Swigert</b>		Address <b>Malta Bend Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency - Prematurity (6 mo. Preg 126 wks)</b>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				DUE TO (c)	
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 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	
21. I attended the deceased from <b>Apr 13</b> , to <b>Apr 13</b> and last saw <sup>him</sup> alive on <b>Apr 13</b>		Death occurred at <b>Apr 13</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>D. Hayschuld MD</b>		22b. ADDRESS <b>Marshall, Missouri</b>		22c. DATE SIGNED <b>4/13/62</b>	
23a. BURIAL, CREMATION, or other disposition of body <b>REMOVED</b>		23b. DATE <b>4-14-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BUFFALO, Mo</b>	
23d. LOCATION (City, town, or county)		24. FUNERAL DIRECTOR <b>Sweeney-Reser Funeral Home</b>		25. DATE RECD. BY LOCAL REG. <b>Marshall 4-13-62</b>	
26. REGISTRAR'S SIGNATURE <b>Cecil G. Reed</b>					

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Student Embalmer No. *This body was not returned embalmed*

Signed *Jack Marshall*

Licensed Embalmer No. *4643*

P. O. Address *Marshall, Mo*

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.