

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035015

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4692

STATE FILE NUMBER

FILED SEP 28 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION
Otto W. Theel

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 83 YEARS	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OR (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 100 EAST 36TH STREET COLONIAL NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4914 MAIN STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRANCES Middle BELL Last SWINGLEY			4. DATE OF DEATH Month SEPTEMBER Day 11 Year 1962
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/5/74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (last birthday) 87 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) AURELIA, IOWA		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME JOHN H. GILMAN		13b. MOTHER'S MAIDEN NAME MARTHA HURBERT	14. NAME OF HUSBAND OR WIFE SAMUEL NEWCOMER SWINGLEY
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 HELEN SWINGLEY Address 808 W. 103 STREET 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) Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hemiparesis of Rt. Neck			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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.		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 <u>May 1, 1962</u> to <u>Sept 11, 1962</u> and last saw her alive on <u>Sept 11, 1962</u> Death occurred at <u>2:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In blue or title) Otto W. Theel M.D.		22b. ADDRESS 4301 Main St. KCMo	22c. DATE SIGNED 9-12-62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE SEPT. 14, '62	23c. NAME OF CEMETERY OR CREMATORY OLATHE CEMETERY	23d. LOCATION (City, town, or county) (State) OLATHE KANSAS
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		ADDRESS 1331 BRUSH CR. KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 9-13-62
			26. REGISTRAR'S SIGNATURE Ruth Long

Dr. Otto W. Stahl
Rear - S. 2nd Floor. 4301 Main Street
1:30 - 5:00

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 Vern Lawler

Licensed Embalmer No. 4915
P. O. Address KS 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.