

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038997

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5290

FILED NOV 1 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF William R. Morris MEDICAL CERTIFICATION

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 Mo. b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in lb 5 weeks	c. CITY OR TOWN Mosby Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION Ostopathic Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Box 87 (4 yrs) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN IRVING SWAN			4. DATE OF DEATH Month Day Year OCTOBER 14, 1962
5. SEX Male	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 April 12, 1874
9. AGE (last birthday) 88		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (City and state or country) Theresa, New York
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Benjamin F. Swan	
13b. MOTHER'S MAIDEN NAME Emma E. Sheppard		14. NAME OF HUSBAND OR WIFE Flora E. Swan	
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 Mrs. Edith F. Crockett-Mosby, Mo. Box 87 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
IMMEDIATE CAUSE (a) Bronchial Pneumonia			3-4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Subdural hematoma			1 1/2 months.
DUE TO (c) Bronchiectasis			1-3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial asthma, senility, arteriosclerosis, malnutrition.			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 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 February 1961 , to 10-14-1962 and last saw him alive on 10-14-1962 Death occurred at 5:45 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>Wm. R. Morris, D.O.</i>	
22b. ADDRESS 10 W. Kansas, Liberty, Mo.		22c. DATE SIGNED 10-17-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-16-1962	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City, town, or county) (State) Liberty, Missouri
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 10-17-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

DR. MORRISON ST 1-0200
10 West Kansas
Liberty, Mo.

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 John D. Herrick, Jr.
Licensed Embalmer No. 4848

P. O. Address K.C. 17, 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.