

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-030568

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 391 Primary Registration District No. 4504 Registrar's No. 12

FILED JUL 20 1965

VS 300 Rev. 4/59	DATE AMENDED
1 <u>1030</u>	
2 <u>0940</u>	
3	
4 <u>0</u>	
5 <u>2</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9 <u>331X</u>	
10	
11	
12 <u>90-0</u>	
13 <u>3-0</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Advance</u>		Length of stay in 1b <u>1 wk.</u>	c. CITY OR TOWN <u>Esther</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Ivan Swacker</u>		4. DATE OF DEATH Month Day Year <u>July 12 1965</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Joseph Lead</u>	11. BIRTHPLACE (City and state or country) <u>Hopewell, Mo.</u>
13a. FATHER'S NAME <u>Robert E. Swacker</u>		13b. MOTHER'S MAIDEN NAME <u>Julie Linza</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>491-18-9910</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular Accident</u>		17. INFORMANT Address <u>Rev. Lawrence Kennon, Advance, Mo.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>2nd A.S. to new C.V.A.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
DUE TO (c)		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 _____ to _____ and last saw her alive on _____ Death occurred at _____; _____ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. K. L. Smith</u>		22b. ADDRESS <u>330 North second Street poplar Bluff, Missouri</u>	22c. DATE SIGNED <u>7-17-65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-13-65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Memorial</u>	23d. LOCATION (City, town, or county) (State) <u>Flat River, Mo.</u>
24. FUNERAL DIRECTOR <u>Sparks-Murphy Funeral Home, Flat River, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>July 19, 1965</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Moore</u>

USE BLACK INK OR TYPEWRITER RIBBON

JUL 21 1965

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 Wm. H. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance, 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.