

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026511

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 280

1. PLACE OF DEATH a. COUNTY <u>St Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Length of stay in 1b <u>11 wks</u>	c. CITY OR TOWN <u>Flat River, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location), HOSPITAL OR INSTITUTION <u>Bonne Terre Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>203 Third St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alonzo</u> Middle <u>Swearinaen</u> Last <u></u>			4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>5/10/89</u>	9. AGE (last birthday) <u>72</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>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lead mining</u>	11. BIRTHPLACE (City and state or country) <u>Iron County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>George Washington Swearinaen</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Sherrill</u>		14. NAME OF HUSBAND OR WIFE <u>Hazel Marie (Clain)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>493-05-0080</u>	17. INFORMANT <u>wife, 203 Third St, Flat River, Mo</u> 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 <u>3 yrs.</u>
IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Bronchitis</u>	
	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.)	
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
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21. I attended the deceased from Aug 3 - 59 to July 20-61 and last saw ^{her}him alive on July 19-61
Death occurred at 3 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C. H. Appleberry M.D.</u>	22b. ADDRESS <u>Rivermires Mo</u>	22c. DATE SIGNED <u>7-21-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7/23/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cem.</u>	23d. LOCATION (City, town, or county) <u>Farmington</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Alvin W. Hood; Flat River, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>July 21, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Cather Redloff</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

JUL 22 1967

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 Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address 1401 Quier, ...

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.