MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11719

File No. 6506

Registered No. 5.

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township Kaw Primary Registration District No. 1002

City Kansas City (No. 4319 Campbell St. Ward)

2. FULL NAME Carlos F. Sweet

(a) Residence. No. 4319 Campbell St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	wh	married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Gussie E. Sweet

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-7-1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	65	8	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Nebraska

PARENTS

10. NAME OF FATHER James Sweet

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) N.Y.

12. MAIDEN NAME OF MOTHER Clementine Emmons

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) New York

14. INFORMANT Gussie E. Sweet
(Address) 4319 Campbell

15. FILED 4/10, 1927 M. M. Crane
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-10-27 19

17. I HEREBY CERTIFY, That I attended deceased from 1921, 19, to 4-10-27, 19, that I last saw ~~he~~ alive on 3-17-27, 19, and that death occurred, on the date stated above, at 10:20 9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) High blood pressure
(duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Leslie B. Miller, M. D.
4/10, 1927 (Address) 1201 Baltimore K.C. Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt Washington	Apr-12 1927
20. UNDERTAKER	**ADDRESS**
Newcomer's Sons	K.C. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] CONTAINING THIS IS A PERMANENT RECORD