

REC'D FEB 24 1939

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

2770  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Johnson Registration District No. 431  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3023 Registered No. 16  
 (c) City Warrensburg (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 578 Patricia Lee Sweeney  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 11 - 1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
9 15

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warrensburg Mo.  
 13. NAME Floyd Huff  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Java

MOTHER  
 15. MAIDEN NAME Virgie Lee Sweeney  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paxson Kansas

17. INFORMANT (ADDRESS) Carrie Banks Warrensburg

18. BURIAL, CREMATION, OR REMOVAL PLACE Funeral Hills DATE Jan 25 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sweeney - Phillip Warrensburg, Mo.

20. FILED Jan 27 1939 Eva Gentry Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan - 26, 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 10<sup>th</sup>, 1939, to Jan 26<sup>th</sup>, 1939. I last saw her alive on Jan 26<sup>th</sup>, 1939. Death is said to have occurred on the date stated above, at 9:00 P.M. The principal cause of death and related causes of importance were as follows:  
Retinitary Adenoma, about July 1939 Date of onset 6  
53'

Other contributory causes of importance:  
I know of none, except a possibility of congenital endocrine deficiency.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_ (Signed) J. B. Hall, M. D.  
 (Address) Warrensburg, 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.

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RECEIVED  
District Health Officer No. 8,  
District File Number 2E/39  
Date Filed

**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, Earl Priest, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Earl Priest

Licensed Embalmer No. 3878

P. O. Address Warrensburg

**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 this body is not embalmed, above space should be left blank.**