

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
3833 Connecticut St 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Charles C Sweany 547

3. (b) If veteran, name war no

3. (c) Social Security No. 712 16 5204

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mae B Sweany 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Nov 3 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

58	9	20	hr. min.
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9. Birthplace Seymour Ind  
(City, town, or county) (State or foreign country)

10. Usual occupation R R Engineer Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William F Sweany

13. Birthplace Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Alpha A Scott

15. Birthplace Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mae B. Sweany

(b) Address 3833 Connecticut

17. Removal Hearse (b) Date thereof 8/25/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Muphrysbrough Ill.

18. (a) Signature of funeral director Wick Bros. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) AUG 25 1940 (b) J. D. Rudick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis 16  
(If outside city or town limits, write "RURAL")

(d) Street No. 3833 Connecticut St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 24  
year 1940 hour 2 minute 20 A. M.

21. I hereby certify that I attended the deceased from 1938  
1938 to Aug 24, 1940  
that I last saw him alive on Aug 23, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Carcinomatosis

Due to Carcinoma of Prostate

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 51

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature A. M. [Signature] (M. D. or other) N/A

Address 1703 So Grand Date signed 8-24-40

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**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.....

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

Signed..... *Henry A. Shumard* .....

Licensed Embalmer No..... 3722 .....

P. O. Address..... 412 Duchouquette St. .....

**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.**