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MAR 11 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6921
State File No. 105

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 105

1. PLACE OF DEATH
 (a) County GREENE
 (b) City or town Springfield
 (c) Name of hospital or institution: Burge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 In this community 3 days
 years, months or days

3. (a) PRINT FULL NAME James Marion Sweet
 3. (b) If veteran, name war No.
 3. (c) Social Security No. None

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife LAVENA Smith Sweet
 6. (c) Age of husband or wife if alive 73 years
 7. Birth date of deceased November 3 1868
 (Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 2 If less than one day
 hr. min.

9. Birthplace Webster Co Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business General Store

MOTHER FATHER
 12. Name Robert Sweet
 13. Birthplace Unknown Tennessee
 (City, town, or county) (State or foreign country)
 14. Maiden name Beliah Bookelf
 15. Birthplace Christian Co Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Hazel Tillman

(b) Address Burge Hospital - Springfield

17. (a) BURIAL (b) Date thereof FEB 7 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fordland, Mo

18. (a) Signature of funeral director Kelly FARRELL

(b) Address Seymour, Mo

19. (a) 2-7-41 (b) W.E. Handley
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Webster
 (c) City or town Fordland
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 5th
 year 1941 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb. 2
1941, to Feb 5 1941;
 that I last saw him alive on February 5 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia and Heart block (2-1)
 Due to latter due to coronary thrombosis
 Due to _____

Other conditions (Include pregnancy within 3 months of death)

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?
9 old
 While at work? _____ (Specify type of place)
 (e) Means of injury _____
 Signature Ray D Callaway (M. D. or other) D
 Address Springfield Mo Date signed 2/6/41

Duration
3d
4d
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

39
629

942

STATE BOARD OF HEALTH
PHYSICIAN
REGISTERED APPRENTICE
EXPIRES
1916

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

X

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

6921
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township St. Louis Primary Registration District No. 2001
(c) City Springfield (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
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 James Marion Sweet

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 3 2

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 5, 1941

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19__

I last saw him alive on _____, 19__. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Myocardial infarction
acute heart block
caused due to coronary thrombosis
Date of onset _____
Other contributory causes of importance: Primary cause of venous not known but was probably arterio-sclerotic renal disease.

Name of operation _____ Date of _____
What test confirmed diagnosis? 1310 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? _____
If so, specify quid Callaway, M. D.
(Signed) _____ (Address) Springfield 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

quid Callaway Springfield

