

S. No. 2  
M-2-43  
5-17-39  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20542

State File No. \_\_\_\_\_

FILED JUL 10 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2843

1. PLACE OF DEATH

(a) County Jackson

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

(c) Name of hospital or institution: 201 Forest 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community 57 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 201 Forest  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES F. Sweeney

3. (b) If veteran, name war no

3. (c) Social Security No. 492-18-8383

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1946 hour 9:30 a.m.

21. I hereby certify that I attended the deceased from May 1, 1946 to June 24, 1946 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of race W

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife unk. Feb

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 17-1889  
(Month) (Day) (Year)

Immediate cause of death: Arteriosclerosis

Due to Arteriosclerosis

Due to Bronchiectasis

Other conditions (include pregnancy within 3 months of death) 94a

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>4</u>	<u>7</u>	hr. _____ min. _____

Duration 38 hrs

Due to Arteriosclerosis

Due to Bronchiectasis

9. Birthplace Kansas City Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Teacher

11. Industry or business National Bell

12. Name Valentine Sweeney

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

14. Maiden name Frances Smith

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

Major findings: 94a

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

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Valentine Sweeney

(b) Address 201 Forest

17. (a) burial (b) Date thereof 6/27-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director John B. Angell

(b) Address K.C. Mo

19. (a) 6-26-46 (b) Steraldine Holmes  
(Date received from registrar) (Registrar's signature)

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? \_\_\_\_\_

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

23. Signature J. E. Shields (M. D. or public health officer)  
Address 922 West 7 Date signed 6-26-46

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

1946

*Dr. Meltz*

*Handwritten notes and scribbles, including "JAN" and other illegible marks.*

**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 *John B. [Signature]*

Licensed Embalmer No. *4273*

P. O. Address. *KC Mo*

**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.**