

FILED APR 8 1947

State File No. _____

Registration District No. 25

Primary Registration District No. 5093

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Bates
 (b) City or town Rich Hill - New Home Twp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 7 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates
 (c) City or town Rich Hill Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. New Home Twp.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Thomas A. Sweeny

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Anno 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 20 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Davis County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name John Sweeny

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

14. Maiden name Elizabeth Miller

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

16. (a) Informant Clyde Sweeny

(b) Address Rich Hill 1230

17. (a) Burial (b) Date thereof 3. 29 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tribune, Kansas

18. (a) Signature of funeral director Culver Underwood

(b) Address No. N Main Butler, Mo

19. (a) Mar 29 1947 (b) Mrs. Cassa Douglas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
 year 1947 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan 10th 1947 to March 25, 1947
 that I last saw him alive on March 25, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure

Due to Myocardial Decompensation

Due to Emaciation & Debility

Other conditions None
(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?
(Specify type of place)

While at work? _____ (e) Means of injury 2

23. Signature Taylor R. Miller (M. D. or other) D.O.
 Address Rich Hill, Mo. Date signed 3-27-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Officer No. 7,
District file number 3-47-367
Date filed 4-5-47

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 G. Anderson
Licensed Embalmer No. 3585
P. O. Address Butler 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 16

Registration District No. 25

Primary Registration District No. 5093

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Rich Hill
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas A. Sweaney

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W
6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Jan 20
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer-retired

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant Glyde Sweaney

(b) Address Rich Hill, R.F.D.

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Edw. Douglas (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 26 Year 1947 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-7825