

S. No. 2
DM-2-43
7-5-17-39
P-I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **310**
Registrar's No. **9**

Registration District No. **42** Primary Registration District No. **1000**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **Saint Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Mo. Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
In this community **1 day**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Harrison**
(c) City or town **Hatfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **Hatfield**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mina Ellen Sweeney**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **1** year **1948** hour **6** minute **30** P. M.
21. I hereby certify that I attended the deceased from **Dec 31**, 1947, to **Jan 1**, 1948 that I last saw her alive on **Jan 1**, 1948 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**
(b) Name of husband or wife **James Augustus Sweeney** 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death: **Acute Bacterial pneumonia** 48 hrs
Myocardial infarction
Due to **Large aortic cyst** 5 yrs.

7. Birth date of deceased **Sept. 24** **1878**
(Month) (Day) (Year)
8. AGE: Years **69** Months **3** Days **7** If less than one day hr. min.

Other conditions (Include pregnancy within 3 months of death)
Major findings: **none**
Of operations: **none**
Of autopsy: **none**

9. Birthplace **Hatfield Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **unknown**
13. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **Bernice Jane Koger**
15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Meimie Todd**
(b) Address **Hatfield, Mo.**
17. (a) **Burial** (b) Date thereof **January 5 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation **Lincoln Center Cemetery**
18. (a) Signature of funeral director **Arch C. Dunfee**
(b) Address **Grant City, Mo.**
19. (a) **Jan 8, 1948** (b) **La L. Jenkins**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature **H. S. Searns** (M. D. or other)
Address **H. S. Searns** Date signed **1-7-48**

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

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..... *Arch. C. Dumble*

Licensed Embalmer No. *3252*

P. O. Address *Grant City, 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.