

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37640**

FILED OCT 30 1953

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10133			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. LENGTH OF STAY (in this place) 4 Days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		d. STREET ADDRESS (If rural, give location) 5727 Goodfellow Blvd., 20,			
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital				7					
3. NAME OF DECEASED (Type or Print) a. (First) EVA		b. (Middle) ELIZABETH		c. (Last) SWEENEY		4. DATE OF DEATH (Month) (Day) (Year) Oct. 22nd, 1953			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec. 22nd, 1891			
9. AGE (In years last birthday) 61		10. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME William Bierach			13b. MOTHER'S MAIDEN NAME Elizabeth Henke			14. NAME OF HUSBAND OR WIFE Late John Thomas Sweeney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Robert John Sweeney, 5727 Goodfellow Blvd. ADDRESS _____					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 1 yr	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Tumor				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION 10/20		19b. MAJOR FINDINGS OF OPERATION Cranioplasty				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from 5/18, 1953 to 10/20, 1953 , that I last saw the deceased alive on 10/20, 1953 , and that death occurred at 5:00P m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) E. A. Omolenc MD				23b. ADDRESS Beaumont Medical Bldg		23c. DATE SIGNED 10/23/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/26/53		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
DATE REC'D BY LOCAL REG. OCT 24 1953		REGISTRAR'S SIGNATURE J. Earl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CALVIN F. FEUTZ, 4828 Natural Bridge Blvd. FUNERAL HOME, INC., St. Louis, 15, Mo.					

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

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *John A. Mlinar*

Licensed Embalmer No. *4186*

P. O. Address *St. Louis 9*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.