

FILED JUN 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH'57 0 2 2 9 3 5  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registration No. 5624

|  |                                  |   |  |   |  |
|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u> |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>St. Louis</u>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <u>E. St. Louis</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <u>Cardinal Glennon</u>  |                                  | Length of stay in 1b<br><u>2 days</u>   | 3. STREET ADDRESS <u>3205 N. Park Dr</u>   |   | (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>DAVID</u> Middle <u>SWEENEY</u> Last <u>SWEENEY</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>JUNE</u> Day <u>15</u> Year <u>1957</u>   |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 7 1948</u>  | 9. AGE (In years last birthday) <u>9</u><br>IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____ |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)<br><u>Child</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>East St. Louis, Ill.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |
| 13. FATHER'S NAME<br><u>Clyde Sweeney</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Joy Deon Powell</u>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  | 17. INFORMANT<br>Address<br><u>Clyde L. Sweeney</u>  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute leukemia</u>   |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>17 months</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |                                  |   |  |   | DUE TO (b) _____<br>DUE TO (c) <u>204.3</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>           |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____<br>a. m. _____ p. m. _____   |                                  |   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |  |
| 21. I attended the deceased from <u>Nov-1956</u> to <u>June 15, 1957</u> and last saw <sup>her</sup> him alive on <u>June 15, 1957</u><br>Death occurred at <u>3:00 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |   |  |
| 22a. SIGNATURE<br><u>[Signature]</u>   |                                  | (Degree or title)<br><u>M.D.</u>  |  | 22b. ADDRESS<br><u>1465 S. Grand Ave.</u>   |  |
| 22c. DATE SIGNED<br><u>6/15/57</u>   |                                  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 23b. DATE<br><u>JUNE 17, 1957</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Clair Memorial Park</u>  |  |
|  |                                  |   |  | 23d. LOCATION (City, town, or county) (State)<br><u>St. Clair County Ill.</u>                                 |  |
| 24. FUNERAL DIRECTOR<br><u>[Signature]</u>   |                                  | ADDRESS<br><u>E. St. Louis, Ill.</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>JUN 17 '57</u>   |  |
|  |                                  |   |  | 26. REGISTRAR'S SIGNATURE<br><u>J. Earl Smith, M.D.</u><br><u>[Signature]</u>                                 |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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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.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No. 31

P. O. Address.....

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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