

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010427  
STATE OF MISSOURI

FILED MAR 17 1959

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 40

5. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Crawford Phelps</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba, Phelps, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Cuba</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp. Cuba</u>		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Rte # 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>McKinley</u> Last <u>Sweeney</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1959</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-1-1894</u>		
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled Businessman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Cuba, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George Sweeney</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Wilson</u>			14. NAME OF HUSBAND OR WIFE <u>May Sweeney</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>May Sweeney, Cuba, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1, 2, and 3° burns involving lungs and 100% of body surface</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		9160 16		
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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Injuries sustained in fire of accidental origin</u>						
20c. TIME OF INJURY Hour <u>7:00</u> a.m. Month, Day, Year <u>Mar 6, 1959</u>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>3 miles W. of Cuba, Crawford Co., Mo.</u>		COUNTY STATE		
21. I attended the deceased from <u>3-6-59</u> , to <u>3-6-59</u> and last saw him alive on <u>3-6-59</u> Death occurred at <u>3:10 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Frank A. Elders</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Cuba Mo.</u>		22c. DATE SIGNED <u>3-8-1959</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-8-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Under Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cuba Mo.</u>		
24. FUNERAL DIRECTOR <u>Paul J. Hanrahan</u> ADDRESS <u>Cuba, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Mar. 16, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>			

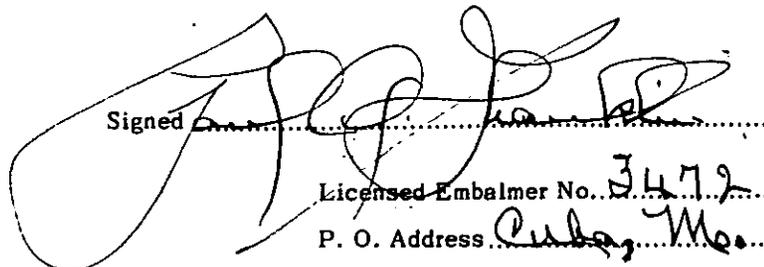
SA  
MAR 18 1959

Date Filed  
MAR 20 1959

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. 3472

P. O. Address Cuba, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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