

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026265

AMENDED **F** Registration District No. 290 Primary Registration District No. 4423 Registrar's No. 46 STATE FILE NUMBER 26265

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Platte</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Weston</b>	a. STATE <b>Missouri</b> COUNTY <b>Platte</b>	c. CITY OR TOWN <b>Rushville</b>
Length of stay in 1b <b>one day</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Matthew's Rest Home</b>		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year	
<b>Charles Sweet</b>			<b>July 30, 1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-1887</b>	9. AGE (last birthday) <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>unknown</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT Address <b>Joseph Conard Atchison, Kan.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH.
IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b>		<b>6 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pleural effusion, chronic pleuritis (x Ray)</b>	<b>Unknown</b>
	DUE TO (c) <b>Old healed tubercular infection</b>	<b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.
<b>Mesothelioma, Chronic pleural thickening (x Ray)</b>		<input checked="" type="checkbox"/> Male <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)
<b>no</b>	<b>XXXXXXXXXXXXXX</b>	<b>XXXXXXXXXXXXXXXXXXXX</b>
20c. TIME OF INJURY Hour a.m. <b>XXXXXX</b> Month, Day, Year <b>XXXXXX</b>	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.) <b>XXXXXX</b>		20f. CITY, TOWN, OR LOCATION <b>Weston, Platte Mo.</b> COUNTY STATE
21. I attended the deceased from <b>July, 25, 61</b> to <b>July, 29, 61</b> and last saw him alive on _____ Death occurred at <b>3 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <b>Lewis P. Albert MD</b> (Degree or title)	22b. ADDRESS <b>Weston, Mo.</b>	22c. DATE SIGNED <b>7/30 61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>8-1-61</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Graceland Cemetery</b> town, or county (State) <b>Weston, Missouri</b>
24. FUNERAL DIRECTOR <b>Vaughn Funeral Home</b> ADDRESS <b>Weston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8.1.1961</b>	26. REGISTRAR'S SIGNATURE <b>B. Phia. Rollins</b>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

**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 Robert D. Braun, Student Embalmer No. 635

working under my personal supervision.

Student Robert D. Braun  
Signature of Student Embalmer

Signed Walter R. Vaughn  
Licensed Embalmer No. 4023

P. O. Address \_\_\_\_\_

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.