

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

9928

1. PLACE OF DEATH

County..... Registration District No. **4791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis Mo.** (No. **MO Pacific Hospital**) St. _____ Ward _____
 Registered No. **2501**

2. FULL NAME

William Riley Sweet
 (a) Residence. No. **County farm** St. **12** Ward. **Winfield Kansas**
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. **1 1/2** mos. _____ da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **M**

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **unknown**

7. AGE YEARS MONTHS DAYS If LESS than 1 day: _____ hrs. or _____ min. **ok. 69**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Fire Alarm**
 (b) General nature of industry, business, or establishment in which employed (or employee) **MO Pac RR**
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Indiana**
 (STATE OR COUNTRY)

10. NAME OF FATHER **unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT **Walter Grothman**
 (Address) **MO. Pac. Hosp**

15. FILED _____ 19 _____
May 6 Starck
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar 12 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 29**, 1927, to **Mar 12**, 1927, that I last saw him alive on **Mar 13**, 1927, and that death occurred, on the date stated above, at **8:30 A** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

serenity
Hypertrophy of Prostate
 (duration) **1** yrs. _____ mos. _____ da.
 CONTRIBUTORY **Cerebral abscess RT**
 (SECONDARY) **Submaxillary. Cause unknown**
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? **abscess developed in Hosp**

DID AN OPERATION PRECEDE DEATH? **Yes**. DATE OF **Mar 11, 1927**

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? **Phy. and laboratory**
 (Signed) **Paul B. Numbauer, M. D.**
 , 19 _____ (Address) **MO. Pacific Hosp.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Winfield Kans** DATE OF BURIAL **3/15 1927**

20. UNDERTAKER **Pete Born 3024 Lafayette St** ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

