

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

Do not use this space.

19817

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **Fused Hospital**)

File No.....
Registered No. **5567** St. _____ Ward)

2. FULL NAME

(a) Residence. No. **6560 Smiley Ave** St. **3** Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Maxwell		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 18 1864		
7. AGE	YEARS 63	MONTHS 3
	DAYS 26	IF LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **clerk**

(b) General nature of industry, business, or establishment in which employed (or employer) **Fused R. P. Co**

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) STATE OR COUNTRY
St. Louis MO

PARENTS

10. NAME OF FATHER **Charles Sweeney**

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

12. MAIDEN NAME OF MOTHER **Margaret Sweeney**

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

14. INFORMANT **Mary Maxwell**
(Address) **6560 Smiley Ave**

15. FILED **15 1927** **19** **1927**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 14 1927**

17. I HEREBY CERTIFY, That I attended deceased from 1-20-1927, to 6-14-1927, and that I last saw him alive on 6-14-1927, and that death occurred, on the date stated above, at 9:20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
broncho pneumonia
197
902
1075
Myocarditis - Chronic (duration) yrs. mos. **4**
CONTRIBUTORY (SECONDARY) **several years**
Operation for hypertrophied prostate
18. WHERE WAS DISEASE CONTRACTED

19. PLACE OF DEATH **yes Prostatectomy**
900 **no** DATE OF **3-23-27**
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **LeBarrough** M.D.
6-14, 1927 (Address) 4960 La Cade
*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 **Salvory Cem** **DATE OF BURIAL** **6/17 1927**

20. UNDERTAKER **Broghan 7146 Manchester**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

