

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

Do not use this space.

14764

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kau Primary Registration District No. 3002 Registered No. 1809
 City Kansas City, Mo. Research 3002 St. _____ Ward _____

2. FULL NAME

Infant Sweeney Arthur Cary
 (a) Residence. No. 705 West 50th St. _____ 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 <u>m</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 15, 1929</u>		
7. AGE	YEARS	MONTHS
	<u>0</u>	<u>0</u>
		DAYS
		<u>0</u>
		IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Arthur Cary Sweeney
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Unifed Sallen
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Texas
 (STATE OR COUNTRY)

14. INFORMANT Arthur Cary Sweeney
 (Address) 705 West 50th

15. FILED 4/16, 1929 M.M. Corrine REGISTRAR
ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 15 1929
 17. I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1929, to Apr. 19, 1929, that I last saw him alive on Apr. 15, 1929, and that death occurred, on the date stated above, at 2:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature in fant
159 (7 months fetus)
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 16/16
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS 4
 (Signed) Robert T. Vandoren, M. D.
4-16-1929 (Address) 918 Medical Arts Bldg

*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 Wichita Kans. DATE OF BURIAL Apr. 16 1929

20. UNDERTAKER S.H. Newcomer's Sons ADDRESS Mo.

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.

918 met. Auto Obliz.
Val. 6767
1:30 - 4:30