

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

Do not use this space.

27373

1. PLACE OF DEATH *New Madrid*
County *Anderson* Registration District No. *55*
Township *Highway* Primary Registration District No. *4093* Registered No. *858*
City (No. *6262*) St. _____ Ward _____

2. FULL NAME *Jess Sweeney*
(a) Residence No. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Single*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 22 1894*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
38 4 20
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer *Anderson Anderson*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 12 1930*
17. I HEREBY CERTIFY, That I attended deceased from *Jan 15* 19*30*, to *Aug 12* 19*30* that I last saw her alive on *Aug 5* 19*30*, and that death occurred, on the date stated above, *6* a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary TB
TBA
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

48. WHERE WAS DEATH CONTRACTED
IF NOT AT PLACE OF DEATH *at home*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *7*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*

(Signed) *R B Meindemeyer* M. D.

, 19 _____ (Address) *Anderson MO*

*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.

9. BIRTHPLACE (CITY OR TOWN) *Cruphelle*
(STATE OR COUNTRY) *MO.*

PARENTS

10. NAME OF FATHER *unknown*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *ind*
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *unknown*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *ind*
(STATE OR COUNTRY)

14. INFORMANT *Geo Waddell*
(Address) *Anderson MO*

15. FILED *Sept 10 1930* *M. V. Mummie*
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Hennett's Cemetery* DATE OF BURIAL *8-13 1930*
20. URBERTAKER *R B Meindemeyer* ADDRESS *Anderson MO*

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.

