

Registration District No. **791**
1008

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community Life years, months or days)

3. (a) PRINT FULL NAME Catherine Sweeney

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Joseph Sweeney 6. (c) Age of husband or wife if 30 years

7. Birth date of deceased Nov 18 1877
(Month) (Day) (Year)

| | | | | |
|---------|-----------|----------|----------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | <u>61</u> | <u>7</u> | <u>6</u> | hr. _____ min. |

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

12. Name THOMAS WALSH

13. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hosp. Info. M. Sull
(b) Address _____

17. (a) CALVARY, BURIAL (b) Date thereof JUNE 27 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director Joseph G. Goodner

(b) Address 2228 Jackson St.

19. (a) JUN 26 1939 (b) J. P. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri / (b) County _____
(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 1619 N. 25th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1939 hour 5:10 minute _____ P. M.

21. I hereby certify that I attended the deceased from 6/23/39
_____, 19____, to 6/24, 19____.

that I last saw h. OR alive on 6/24, 19____.

and that death occurred on the date and hour stated above.

Immediate cause of death
Diabetes Mellitus
Cerebral Embolism

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Gen. M. [Signature] (M. D. or other)

Address City Hospital Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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

Charles Goodhart

Registered Apprentice No.

working under my personal supervision.

Charles Goodhart

Signed

Licensed Embalmer No.

2777

P. O. Address

St Louis Mo

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 this body is not embalmed, above space should be left blank.