

0. 2  
10-39  
7-39  
K21492

FILED OCT 11 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30892**  
Registrar's No. **3455**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution: **Wm. A. A. General Hospital**  
(d) Length of stay: In hospital or institution **6 days**  
In this community **25 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(d) Street No. **Unknown--Transient**  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **CLARENCE SWEET**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **April 8th 1861**

8. AGE: Years **79** Months **4** Days **24** If less than one day hr. min.

9. Birthplace **Hornell New York**

10. Usual occupation **Transferman**

11. Industry or business

MOTHER FATHER

12. Name **Jerry J Sweet**  
13. Birthplace **Seneca Falls N. Y.**  
14. Maiden name **Maria Temple**  
15. Birthplace **an ocean**

16. (a) Informant **Martha Williams**

(b) Address **1014 Jefferson Topeka Kan**

17. (a) **Removal** (b) Date thereof **Sept 3-40**

(c) Place: burial or cremation **Topeka Kansas**

18. (a) Signature of funeral director **Benson Funeral Home**  
(b) Address **Topeka Kansas**

19. (a) **Sept. 3, 1940** (b) **M. M. Brown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **1st**  
year **1940** hour **5:00** minute **25** A. M.

21. I hereby certify that I attended the deceased from **8-25-40** to **9-1-40**  
that I last saw h. im. alive on **9-1-40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**  
Due to **See above**  
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy **See above**

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

28. Signature **Dr. R. Thorn** (M. D. or other)  
Address **Ed. Dir. Hospital** Date signed

Duration  
PHYSICIAN  
**92a**  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**