

FILED SEP 24 1945

Registration District No. 11

Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly - 411 Fairfield
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether)
In this community several years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 411 Fairfield
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

James Willie Sweetman

3. (b) If veteran name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4th
year 1945 hour 4 minute 30 M.

21. I hereby certify that I attended the deceased from Sept 2/45 to Sept 4/45
that I last saw him live and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction - several months

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (c) Age of husband or wife if alive 77 years

6. (b) Name of husband or wife Sarah White Sweetman

7. Birth date of deceased May 13 1866

8. AGE:

Years 79 Months 2 Days 21 hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business Farming

12. Name James H. Sweetman

13. Birthplace Mo
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Clayton

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs James W Sweetman

17. (a) burial (b) Date thereof 8-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director W. H. Thompson

19. (a) 9-6-45 (b) Irma Hall
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

Other conditions arterial hypertension
(Include pregnancy within 3 months of death) arthritis

Major findings: Of operations _____

Of autopsy 932

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(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) _____ (Means of injury)

23. Signature Dr. R. E. ... (M. D. or D.O.)

Address Moberly Mo Date signed 9-6-45

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

RECEIVED

District Health Officer No. 10

District File Number 9-45-1490

Date Filed SEP 19 1945

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

Mr. Freda Thompson

Licensed Embalmer No.

3282

P. O. Address

Madison, Ind.

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, fact should be so stated above.