

FILED FEB 2 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 533

BIRTH NO. _____		REG. DIST. NO. <u>64</u>		PRIMARY REG. DIST. NO. <u>4109</u>		Registrar's No. <u>7</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>CHARITON</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KEYTESVILLE</u>		a. STATE <u>MO</u>		b. COUNTY <u>CHARITON</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KEYTESVILLE MO</u>		c. LENGTH OF STAY (in this place) <u>ALL-NER-WIFE</u>		d. STREET ADDRESS (If rural, give location) <u>227-CENTER-ST.</u>		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KEYTESVILLE MO</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>227-CENTER-ST.</u>				d. STREET ADDRESS (If rural, give location) <u>227-CENTER-ST.</u>			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>BERTIE</u>		b. (Middle) <u>SWEATMAN</u>		c. (Last) <u>SWEATMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN-19-1950</u>	
(Type or Print)							
6. COLOR OR RACE <u>BLACK</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>MARCH 19 1906</u>		9. AGE (In years last birthday) <u>43</u>	
5. SEX <u>FEMALE</u>						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
						11. BIRTHPLACE (State or foreign country) <u>KEYTESVILLE - MO</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>BAN. WILLIAMS</u>		13b. MOTHER'S MAIDEN NAME <u>MANERIVA-JANE WOODS</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES SWEATMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ROBERTA PAGE</u> ADDRESS <u>KEYTESVILLE MO</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential Hypertension</u>					
		DUE TO (c) <u>Arteriosclerosis</u>					
		II. OTHER SIGNIFICANT CONDITIONS: <u>Cerebral Thrombosis</u>					<u>42m</u>
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/12</u> , 19 <u>49</u> , to <u>1-19</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>50</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert A. Page M.D.</u>			23b. ADDRESS <u>Keytesville, Mo.</u>			23c. DATE SIGNED <u>1-19-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JAN 22 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KEYTESVILLE MO</u>	
DATE REC'D BY LOCAL REG. <u>1-28/50</u>		REGISTRAR'S SIGNATURE <u>Robert A. Page</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. + J. H. Hest</u>		ADDRESS <u>KEYTESVILLE MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED

JAN 30

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-31-50

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~~ \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed H. D. Garrett

Licensed Embalmer No. 3046

P. O. Address 7544 Terrill 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, fact should be so stated above.