

Health,
& Welfare
S. Public
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S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 31 1957

44973
STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 135

1. PLACE OF DEATH a. COUNTY Lawrence			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Mt. Vernon		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home		Length of stay in lb 2 1/2 years	d. STREET ADDRESS (If outside, give location) State Sanatorium		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ethyle Sweaney			4. DATE OF DEATH Dec. 17, 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1896	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Catherine, Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Augustus King		13b. MOTHER'S MAIDEN NAME Anna Maude Wilson		14. NAME OF HUSBAND OR WIFE Henry C. Sweaney, M. D.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Henry C. Sweaney, M.D., Mt. Vernon, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aneurysm of aorta					INTERVAL BETWEEN ONSET AND DEATH 1 hr. 45 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis, generalized					years
DUE TO (c) Arterial hypertension					several yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from June 17, 1957 to Dec. 17, 1957 and last saw her ^{alive} on Dec. 17, 1957 Death occurred at 3:45 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J. Lewis Zatec, M.D.			22b. ADDRESS Mt. Vernon, Missouri		22c. DATE SIGNED 12-17-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-17-57	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Chicago Ill.	
24. FUNERAL DIRECTOR Max L. Forett		ADDRESS Mt Vernon Mo	25. DATE RECD. BY LOCAL REG. 12-17-57	26. REGISTRAR'S SIGNATURE Cecil Hendricks	

VS JUL 27 1959

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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
Signature of Student Embalmer

Signed *Max L. Smith*

Licensed Embalmer No. *1252*

P. O. Address... *W. H. ...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.