THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007692
STATE FILE NUMBER

FILED MAR 2 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1223

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits: Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: City Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 3225 N.Florissant Ave. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First John — Middle Joseph — Last Sweeney
4. DATE OF DEATH: Month Feb. Day 3 Year 1959
5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 30,1883
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Showman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Hartford,Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Thomas Sweeney
14. MOTHER'S MAIDEN NAME: Bridget Burnes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 498-07-0908
17. INFORMANT: A Sister Seraphine, Address: 3225 N.Florissant Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio Scleratic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arterio Sclerosis
DUE TO (c): 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 ..... to ..... and last saw her/him alive on .....
Death occurred at 11:5A m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Joseph M. Quinn (Degree or Title) Deputy Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 2/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb.6,1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Missouri
24. FUNERAL DIRECTOR: Arthur J. Donnelly — ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: FEB 4 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.