

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019690

STATE FILE NUMBER

24584

SL 19800
FILED MAY 22 1959

Registration District No. Primary Registration District No.

34
800
57
293
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST. LOUIS MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Length of stay in lb 13 DAYS	d. STREET ADDRESS 4944 PAGE BLVD
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES W. SWEET			4. DATE OF DEATH Month Day Year MAY 10 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY UNK	9. AGE (In years last birthday) 66
11. BIRTHPLACE (City and state or country) SEDALIA, MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME ALLEN E. SWEET		13b. MOTHER'S MAIDEN NAME SADIE ROBINSON	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES		16. SOCIAL SECURITY NO. UNK	17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST. LOUIS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 14 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			491x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ABSCESS RIGHT UPPER LOBE EMPYEMA BILATERALLY			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 4/27/59 to 5/10/59 and last saw ^{him} alive on 5/10/59 Death occurred at 9:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. H. Johnson, M.D.		(Degree or title) 0	22b. ADDRESS VAH, ST. LOUIS, MO.
22c. DATE SIGNED 5-10-59			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	5-12-59	Oak Hill Cemetery	Kirkwood, Mo.
24. FUNERAL DIRECTOR Parker-Aldrich, Webster Groves		25. DATE RECD. BY LOCAL REG. MAY 11 1959	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Lucie Welch*

Licensed Embalmer No. *439*

R. O. Address *Wabster Gro*

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.