

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023902  
STATE FILE NUMBER

FILED JUN 16 1959

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 128

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada Hospital</u>		Length of stay in lb <u>55 years</u>	d. STREET ADDRESS (If outside, give location) <u>326 E. Douglas</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NELSON</u> Middle <u>ROBERT</u> Last <u>SWEETS</u>			4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 15, 1883</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor, retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm and Home S&amp;L</u>	11. BIRTHPLACE (City and state or country) <u>Montrose Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Peter Sweets</u>		13b. MOTHER'S MAIDEN NAME <u>Hannah Sutton</u>		14. NAME OF HUSBAND OR WIFE Deceased <u>Marguerite Lacy Sweets</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Dollie Macks Appleton City, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u>					Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</u>					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 <u>Sept, 1955</u> to <u>June 2, 1959</u> and last saw <del>him</del> <sup>her</sup> alive on <u>June 2, 1959</u> Death occurred at <u>Nevada Missouri</u> <u>2:10 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>L. P. McCann</u> (Degree or title) <u>L. P. McCann, M. D.</u>			22b. ADDRESS <u>Moore Bldg., Nevada, Missouri</u>		22c. DATE SIGNED <u>6/6/1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Deepwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Nevada Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ferry Funeral Home Nevada, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>6-6-1959</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, Missouri State Health Department, St. Louis, Mo. All diseases in Part I must be causally related.

Feb. 3 1962

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 *L. Hughes Ferry* .....

Licensed Embalmer No. *4760* .....

P. O. Address *M. ...* .....

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.