

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034705

FILED VS SEP 21 1959

Registration District No. 917 Primary Registration District No. 547 Registrar's No. 2280

STATE FILE NUMBER

RENDERED

| | | | | | | | | |
|---|--|---|--|--|---|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmonds Heights</u> | | Length of stay in 1b <u>36 HRS.</u> | | c. CITY OR TOWN <u>St. Louis</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>St. Marys</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>2712 a Sullivan Ave.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Sweet</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>59</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/21/59</u> | 9. AGE (last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HR | |
| | | | | | | Months | Days | |
| | | | | | | <u>36</u> | Hours | |
| | | | | | | Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | | 11. BIRTHPLACE (City and state or country) <u>St. Louis Co. Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Jerome H. Sweet</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Carol Ann Coerver</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Jerome Sweet</u> None | | |
| 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. <u>None</u> | | 17. INFORMANT Address <u>Mr. Sweet 2712 A Sullivan Ave</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>Hyaline Membrane Disease.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) | | | | | DUE TO (c) <u>773.0</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 a.m. p.m. | | Month, Day, Year | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <u>8/21/59</u> to <u>8/22/59</u> and last saw <u>her</u> alive on <u>8/22/59</u> Death occurred at <u>11:20 pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (In free or title) <u>[Signature]</u> | | | | 22b. ADDRESS <u>3438 So Grand</u> | | 22c. DATE SIGNED | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>8/24/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>St. Louis MO.</u> | | (State) | |
| 24. FUNERAL DIRECTOR <u>Robert D. Kinealy</u> ADDRESS <u>2228 St. Louis Ave.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>8-23-59</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Robert D. Kincaid
J. J. J. J. J.

Licensed Embalmer No. _____

P. O. Address _____

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.