I DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-039472
STATE FILE NUMBER

ILED VS NOV 15 1960

Registration District No. 316 Primary Registration District No. — Registrar's No. 437

1. PLACE OF DEATH a. COUNTY: St. Francois	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Esther — Length of stay in 1b: 7 Months	c. CITY OR TOWN: Desloge — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Route #2 — Inside Limits: Yes ☐ No ☒	d. STREET ADDRESS (If outside, give location): 300 S Main — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Florence	Angeline	Sweeney	Nov.	8th.	1960

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Female	White		June 26,	1871 - 89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Housewife		Kentucky	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND
James Whittaker	Elizabeth Fullington	William Sweeney (Dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	Mrs. Clara Snelson, Esther, Mo.

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): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Hr.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arterio-sclerosis (Senile)

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): arterio-sclerotic heart disease Bronchopneumonia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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 June 8 1939 to Nov 8 1960 and last saw her/him alive on 11-3-60

Death occurred at ____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
H.O. Loebe MD	Desloge Mo	11-9-60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
Burial	11/11/1960	St. Francois Mem Pk.	Bonne Terre,	Mo

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
C.Z. BOYER & SON Desloge, Mo	Nov. 9, 1960	Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed B. A. Boyer

Licensed Embalmer No. 366

P. O. Address Alexander

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