

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

9893

1. PLACE OF DEATH

County Cass Registration District No. 156
Township Grand River Primary Registration District No. 5219
City..... (No.....) St..... Ward.....

File No.....
Registered No. 101
St..... Ward.....

2. FULL NAME

George B. Weaver

(a) Residence. No..... St..... Ward..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 29 1929

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jennie Weaver

17. I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to March 29, 1929, that I last saw him alive on March 29, 1929, and that death occurred, on the date stated above, at 9:35 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28-1853

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uraemic Coma with Erythema of Face

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 10 1

CONTRIBUTORY (SECONDARY) 2/10 (duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

10. NAME OF FATHER John Weaver

WAS THERE AN AUTOPSY.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

WHAT TEST CONFIRMED DIAGNOSIS (Signed) J. J. Scott M. D.

12. MAIDEN NAME OF MOTHER Margaret Weaver

, 19 1929 Address Harrisonville Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Maudie A. Donath (Address) Harrisonville Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Orient 3/31 1929

15. FILE NO. 2/29 1929 D. S. Long REGISTRAR

20. UNDERTAKER ADDRESS
Rummerburg Bos Rd Harrisonville Mo

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1929 24 1929 2 2 2

