

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT

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

22 1930

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

Do not use this space.

1. PLACE OF DEATH

County Dade
Township Cedar
City (No.)

Registration District No. 238
Primary Registration District No. 3326

File No. 38935
Registered No.
St. Ward

2. FULL NAME

John Charles Weste

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

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ruby Weste

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 22, 1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
33 8 11

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)

9. BIRTHPLACE (CITY OR TOWN) Stockton Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Herman Weste
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mrs Ruby Weste
(Address)

15. FILED 12-10-1930 J. A. [Signature]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 3, 1930

17. I HEREBY CERTIFY that I attended deceased from Dec 3 to 30, 1930, that I last saw him alive on 30, 1930, and that death occurred, on the date stated above, at 5:30 A.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
High Blood pressure
Sudden Death, Heart Attack
75 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

19. WAS THERE AN AUTOPSY? WHAT TEST CONFIRMED DIAGNOSIS (Signed) H. Higgins, M. D.

12/4 1930 (Address) Arcola, Mo.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Bethel DATE OF BURIAL Dec. 5 1930

20. UNDERTAKER [Signature] ADDRESS Lockwood Mo.

