

REC'D MAY 11 1939

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

14260

Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan Registration District No. 85
(b) Township Washington Primary Registration District No. 1001 Registered No. 383
(c) City St. Joseph (d) Street No. Missouri Methodist Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 11 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME U. S. Mary Kathleen Weller
(a) Residence, No. _____ St. Newtown Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 2 1936

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 4 7

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. child
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Newtown
(STATE OR COUNTRY) Missouri

13. NAME Oliver Woodrow Weller
14. BIRTHPLACE (CITY OR TOWN) Albany
(STATE OR COUNTRY) Missouri

15. MAIDEN NAME Edith Quinn
16. BIRTHPLACE (CITY OR TOWN) Albany
(STATE OR COUNTRY) Missouri

17. INFORMANT Oliver W. Weller
(ADDRESS) Newtown Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Albany Mo. DATE April 9 1939

19. FUNERAL DIRECTOR (NAME) Walter Bette Bourman Funeral
(ADDRESS) St Joseph Mo.

20. FILED 4/10 1939 H. M. McElhugh
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 9 1939

22. I HEREBY CERTIFY, That I attended deceased from March 2 1939, to April 9 1939

I last saw him alive on April 9 1939 Death is said to have occurred on the date stated above, at 11:15 a.m.

The principal cause of death and related causes of importance were as follows:

Nephritis - acute tubular Date of onset 3-2-39

Other contributory causes of importance:

Acute sore throat 3/2/39

Name of operation none Date of _____
What test confirmed diagnosis? Laboratory Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) W. J. Moore M. D.

(Address) St Joseph, Mo

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.
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.

1150

PHYSICIAN
STATE OF MISSISSIPPI
EMBALMER

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 Apr. 9, 1917
....., or by ✓

Registered Apprentice No....., working under my personal supervision.

Signed W. E. Sumner

Licensed Embalmer No. 3407

P. O. Address 319 So. 4th St.

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township St Joseph Primary Registration District No. 1001 Registered No. 383
 (c) City St Joseph (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mary Kathleen Keller
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>S</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>2</u>	MONTHS <u>4</u>
	DAYS <u>7</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
13. NAME		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19__		
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED _____ 19__		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-9 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 19__

I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

nephritis acute
tubular (following acute streptococcus throat)
acute sore throat

Date of onset 2-12-39

Other contributory causes of importance:
115c

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19__
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ M. D.
 (Signed) M. P. Moore
 (Address) St. Joseph Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S FULL STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

Local Registrar.

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