

Registration District No. 496

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Linn
 (b) City or town Brookfield, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community 50 yrs.
 years, months or days

3. (a) PRINT FULL NAME Ida May Weaver 160

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Husband (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 5, 1858
 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>81</u> | <u>3</u> | <u>20</u> | hr. _____ min. |

9. Birthplace Pike Co. Illinois
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name George VanZandt

18. Birthplace Penn.
 (City, town, or county) (State or foreign country)

14. Maiden name Susan Kurzman

15. Birthplace Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bert Weaver

(b) Address Brookfield, Mo. Monroe St

17. (a) Burial (b) Date thereof 11/26/1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laclede, Mo

18. (a) Signature of funeral director Mrs. Sharpe

(b) Address Laclede, Mo.

19. (a) Nov 26 39 (b) Groves
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 25
 year 1939 hour 2 minute 4 M.

21. I hereby certify that I attended the deceased from Nov 21
 _____, 1939 to Nov 23, 1939;
 that I last saw her alive on Nov 24, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Cerebral Hemorrhage
Rt. Hemiplegia
Arterio-sclerosis General
Unclear

Duration

4 days

Due to _____
 Due to _____

Other conditions (Include pregnancy within 5 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature James W. [unclear] (M. D. or other) _____
 Address Brookfield Mo Date signed 11-26-39

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.

RECEIVED

Dist. Health Officer No. 11.

1239-1654

DEC 6 1939

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 Lic

W. G. Thorne

Registered Apprentice No.

working under my personal supervision.

Signed

W. G. Thorne

Licensed Embalmer No. 2876

P. O. Address Laclede, Mo.

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.