

13-40  
7-39  
X23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24699

State File No.

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 824

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Meth. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 days  
(Specify whether  
In this community 45 years  
years, months or days)

3. (a) PRINT FULL NAME Samuel Weiner 560  
(b) If veteran, name war none  
(c) Social Security No. none

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased Mar. 5th, 1866  
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 24  
If less than one day  
hr. min.

9. Birthplace Unknown Poland  
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business 7

12. Name Sam Weiner

13. Birthplace Unknown Poland  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant Herman Weiner

(b) Address 1306 S. Noyes St. Joseph, Mo.

17. (a) Burial (b) Date thereof 7-30-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shaare Sholem

18. (e) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) July 30, 1940 (b) H. J. Neelbush  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 918 Sylvania  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29th  
year 1940 hour 1 minute 50 A. M.

21. I hereby certify that I attended the deceased from July 23, 1940, to July 29, 1940  
that I last saw him alive on July 29, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy  
Duration 6 days

Due to Hypertension

Due to 82W

Other conditions (Include pregnancy within 3 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?  
85

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

23. Signature H. J. Neelbush (M. D. or other) 12/10  
Address 620 S. Union Date signed 7-30-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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 me

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

Signed Geo E Daniel

Licensed Embalmer No. 3300

P. O. Address Dr Joseph W

**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, fact should be so stated above.**