

Registration District No. 7-96

Primary Registration District No. 6039

Registrar's No. 143

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall Rural  
(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 2  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Jacob Weis

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

7. Birth date of deceased Oct 25 1848  
(Month) (Day) (Year)

8. AGE: Years 91 Months 10 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name John Weis

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Frank Weis

(b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof Sept 17, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park

18. (a) Signature of funeral director Don Short

(b) Address Marshall, Missouri

19. (a) 9-17-40 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1 mile north Marshall  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15  
year 1940 hour 2:30 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from May 31, 1940 to Sept. 15, 1940  
that I last saw him alive on Sept. 15, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown Duration \_\_\_\_\_  
No particular disease.  
General decline of  
Due to senility, gradual  
failure for more than  
Due to a year

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 162  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

28. Signature P. Manning (M. D. or other) \_\_\_\_\_  
Address Marshall, Mo Date signed 9-17-40

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

Rev. 5-17-39  
1-1-1951

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.

MOTHER FATHER

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 10-10-40

**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.....

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

Signed Donald W. Short

Licensed Embalmer No. 3757

P. O. Address Marshall, Missouri

**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.**