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DEPARTMENT OF COMMERCIAL BUREAU OF THE STATE OF MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35658

State File No. _____

Registration District No. 449

Primary Registration District No. 4267

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 214 POLK
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20
(Specify whether _____)

In this community 21 YRS.
years, months or days

3. (a) PRINT FULL NAME GEORGE W WEAVER

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife TUREY MASTERS

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased AUG 6 1856
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>2</u>	<u>13</u>	hr. _____ min. _____

9. Birthplace LACLEDE Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business _____

12. Name WESLEY WEAVER

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

14. Maiden name SUSAN WHITSON

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

16. (a) Informant Turey Weaver

(b) Address Lebanon Mo

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

(c) Place: burial or cremation WHITSON CEM.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) 10-19-40 (b) J. A. M. Comb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LACLEDE

(c) City or town LEBANON
(If outside city or town limits, write "RURAL")

(d) Street No. 214 Polk
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1940 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept. 10-40
_____ 19____ to Oct 19, 1940
that I last saw him alive on Oct 17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic nephritis

Duration 2 year

Due to _____

Due to 1/31

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? 404

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

23. Signature W. A. Hamilton (M. D. or other) _____
Address Lebanon, Mo. Date signed 10-19-40

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

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1620

Date Filed 11-13-40

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 Rob Palmer.....

Licensed Embalmer No. 1161.....

P. O. Address Rob Palmer.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.