

7-39
7-39
K223159

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

1. PLACE OF DEATH:
(a) County **SUCHANAN**
(b) City or town **ST. JOSEPH**
(c) Name of hospital or institution **STATE HOSPITAL No. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
In this community **2 days** years, months or days **3**

3. (a) PRINT FULL NAME **JOHN WEIGHTMAN**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **m** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Maude** 6. (c) Age of husband or wife if alive **? ?** years
7. Birth date of deceased (Month) **?** (Day) **?** (Year) **?**

8. AGE: Years **Est. 75** Months **?** Days **?** If less than one day _____ hr. _____ min.

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

10. Usual occupation **clerk**

11. Industry or business **?**

12. Name **?**

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

14. Maiden name **?**

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

16. (a) Informant **Paul Weightman**

(b) Address **Forest City, Mo**

17. (a) **11/26/40** (b) Date thereof **11-26-40**
(Month) (Day) (Year)

(c) Place: burial or cremation **Forest City, Mo**

18. (a) Signature of funeral director **Gold**

(b) Address **Forest City, Mo**

19. (a) **11/25/40** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Holt**
(c) City or town **Forest City**
(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 **November** day **24**
year **1940** hour **3** minute **30** a. M.

21. I hereby certify that I attended the deceased from **November 23**, 19**40** to **Nov. 24**, 19**40**; that I last saw him alive on **November 23**, 19**40**; and that death occurred on the date and hour stated above.

Immediate cause of death: **Broncho-pneumonia**

Due to _____

Due to **1077**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) **none**

(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 **J. R. Bunch** (M. D. or other) **MD**
Address **State Hospital No 2** Date signed **11-24-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

R. V. Werst

Registered Apprentice No. *3876*

working under my personal supervision.

Signed.....

R. V. Werst

Licensed Embalmer No. *3876*

P. O. Address *St. Joseph 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, fact should be so stated above.