

JAN 15 1941 **293**

Primary Registration District No. **5411**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Franklin
 (b) City or town Rural - Boles Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Villa Ridge, Mo. R.F.D.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no.
(Specify whether)
 In this community 1 yr 3 mo 9 da.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Franklin
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Villa Ridge, Mo. R.F.D.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME EVELYN CLARA ELIZABETH WEBER

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

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

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

7. Birth date of deceased September 5, 1939
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 9 If less than one day _____
hr. min.

9. Birthplace Villa Ridge Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Edmund A. Weber

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

14. Maiden name Frances M. Tuengel

15. Birthplace Villa Ridge Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Edmund A. Weber

(b) Address Villa Ridge, Mo. R.F.D.

17. (a) Burial **(b) Date thereof** Dec. 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Villa Ridge, Mo. (St. John)

18. (a) Signature of funeral director Nieburg & Witt

(b) Address Washington, Missouri

19. (a) 12-15-40 **(b)** Mary Bross
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 14
 year 1940 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from Dec. 10, 1940
 _____, 19____, to Dec. 14, 1940;

that I last saw him alive on Dec 13, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration

Due to _____

Due to _____

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) _____

(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? 261
(Specify type of place)
 While at work _____ **(e) Means of injury** _____

23. Signature J.P. Bross M.D. (M. D. or other) _____
 Address Washington Mo Date signed _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

1072

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

Lester H. Vitt

Registered Apprentice No. _____

working under my personal supervision.

Signed

Lester H. Vitt

Licensed Embalmer No. 3254

P. O. Address Washington, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42447
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 293

Primary Registration District No. 5411

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

1. PLACE OF DEATH:

(a) County Franklin
 (b) City or town Bales 1, 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 _____ (Specify whether)
 years, months or days)

3. (a) ~~PRINT~~ Full Name Evelyn Clara Elizabeth Weber
 (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
 7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>3</u>	<u>9</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
 (Date received local registrar)

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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
 that I last saw him _____ alive on _____ 19 _____
 and that death occurred on the date and hour stated above.
 Immediate cause of death Broncho pneumonia
There were no complications
due to this kind of pneumonia
illness.

Due to _____
 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) _____
 (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 [Signature] (M. D. or other)
 Address [Address] Date 3/17/41

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

