No. 2
-1-4-41
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 10 1941 85

Registration District No.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 21210

Registrar's No.

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 21 days (Specify whether years, months or days)
In this community 15 years

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. 2402 S. 10th.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME BELL WEAVER
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jacob Weaver
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased Feb. (Month) 1st. (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
75	4	27	hr. min.

9. Birthplace Dallas (City, town, or county) Texas (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Joseph Marsh
13. Birthplace Dallas (City, town, or county) Texas (State or foreign country)
MOTHER
14. Maiden name Ann Woods
15. Birthplace Dallas (City, town, or county) Texas (State or foreign country)
16. (a) Informant Jacob Weaver
(b) Address 2402 S. 10th. St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6--30--41 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery
18. (a) Signature of funeral director FLEEMAN & SON, INC.
(b) Address St. Joseph, Mo.
19. (a) July 1 1941 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th. year 1941 hour 11 minute 00 P. M.
21. I hereby certify that I attended the deceased from 6-7, 1941, to 6-28, 1941; that I last saw her alive on 6-28-41, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	
Hypostatic pneumonia	
Due to: Transversal fracture, left femur	
Due to: —	
Other conditions: — (Include pregnancy within 3 months of death)	
Major findings: Of operations: —	
Of autopsy: Cerebral Hemorrhage	

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) Accident
(b) Date of occurrence June 7th 1941
(c) Where did injury occur? St. Joseph (City or town) Buchanan (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fall in back yard at home (Specify type of place)
While at work? No (e) Means of injury Fall
23. Signature Owen W. Craig (M. D. or other) MD
Address St. Joseph, Mo. Date signed 6-28-41

(Licensed Embalmer's Statement on Reverse Side)

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.....Carl W. Hause

Licensed Embalmer No.....3955

P. O. Address.....St Joseph, M

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

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