

5-17-39

X3287

REC MAR 16 1943
Registration District No. 315

Primary Registration District No. 4460

Registrar's No. _____

1. PLACE OF DEATH

(a) County St. Clair
(b) City or town Passaic
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 33 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Clair
(c) City or town Passaic
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) no
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROSLAN N. WEBER

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 year 1943 hour 6 minute 9 M.
21. I hereby certify that I attended the deceased from Feb - 16 - 1943 to Feb - 16 - 1943

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife James Weber 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 4 29 1858
(Month) (Day) (Year)

that I last saw her alive on Feb - 16 - 1943 and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial Infarction
Chronic

8. AGE: Years 84 Months 9 Days 15 If less than one day _____ hr. _____ min.

Due to unknown

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

Due to unknown

10. Usual occupation Housekeeper

Other conditions none (Include pregnancy within 3 months of death)

11. Industry or business _____
12. Name Not known
13. Birthplace Not known (City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace Not known (City, town, or county) (State or foreign country)

Major findings: Of operations none
Of autopsy _____

16. (a) Informant Family Record
(b) Address _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence no
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-43 (Month) (Day) (Year)
(c) Place: burial or cremation Passaic Cemetery

While at work? no (Specify type of place) (e) Means of injury none

18. (a) Signature of funeral director Richardson
(b) Address no

23. Signature J. Richardson (M. D. or other)
Address Missouri Date signed 3/16/43

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

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 71

Order No.

Date filed

2-43-87
3-8-43

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

Chas Gilbert Hathaway

Licensed Embalmer No.

4267

P. O. Address

Osceola, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11283
Registrar's No. _____

Registration District No. 315 Primary Registration District No. 446a

1. PLACE OF DEATH:

(a) County St Clair
(b) City or town Roscoe
(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 _____ years, months or days

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rosem H. Weber

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased April 29 1884
(Month) (Day) (Year)

8. AGE: Years 84 Months 9 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
{ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

19. (a) 3-6-1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 15 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-11283