

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **14848****D MAY 14 1943**Registration District **5755**Primary Registration District No. **5755**Registrar's No. **59**

1. PLACE OF DEATH:

- (a) County **Marion**
 (b) City or town **Vienna**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rural Blackson Imp
 (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

3. (a) PRINT FULL NAME

JOSEPH WEIDER3. (b) If veteran,
name war _____3. (c) Social Security
No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married,
 divorced **Widowed**
 (b) Name of husband or wife **Francis Barth** 6. (c) Age of husband or wife if
 alive _____ years

7. Birth date of deceased

(2/24/1888) (Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

81**2****13**

hr. min.

9. Birthplace

Blotenheim, France
(City, town or county) (State or foreign country)

10. Usual occupation

Farming

11. Industry or business

- MOTHER FATHER
 12. Name **Peter Weider**
 13. Birthplace **Not Known** 9
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Muller**
 15. Birthplace **Not Known** 9
 (City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Weider Jr.**
 (b) Address **Vienna, Mo.**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3/12/1943**
 (Month) (Day) (Year)

(c) Place: burial or cremation

Visitation Cemetery

18. (a) Signature of funeral director **T. S. Wofford**
 (b) Address **Vienna, Mo.**
 19. (a) **4-5-43** (b) **Erma Barrett**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo** (b) County **Marion**
 (c) City or town **Vienna**
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **March** Day **10**
 year **1943** hour _____ minute **204** M.

21. I hereby certify that I attended the deceased from **March 2**, 19**43** to **March 9**, 19**43**
 that I last saw him alive on **March 9**, 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death

Acute Nephritis 8 days

Due to _____

Due to _____

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?

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature **J. C. Howard** (M.D. or other) **2**
 Address **Vienna, Mo.** Date signed **4/2/43**

1046 (Licensed Embalmer's Statement on Reverse Side)

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

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.....

March 10/43
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No. *3341*

P. O. Address *Union 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14848
Registrar's No. 59

Registration District No. 207

Primary Registration District No. 5755

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Vienna
(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 years, months or days)

3. (a) PRINT FULL NAME

Joseph Weider

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) (Month) (Day)

7. Birth date of deceased

Dec. 24
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

(If less than one day min.)

81

2

13

9. Birthplace

(City, town, or county)

(State or foreign country)

France

10. Usual occupation

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

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Maries
(c) City or town Vienna
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 1943 year hour minute M.

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

acute Nephritis

Due to

Due to

Cause unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

8da.

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

J. C. Howard
Vienna, Mo.

Date signed 3/2/43

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

SUPPLEMENTARY

5-14848