

Registration District No. 141

Primary Registration District No. 5551

1. PLACE OF DEATH:

(a) County Howell Howell Twp.
(b) City or town West Plains
(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 14 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. RURAL
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Dale Weeks

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

4. Sex MALE 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 28 - 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 5 hr. min.

9. Birthplace West Plains Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

12. Name John Adam Weeks
13. Birthplace Howell Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name MARY HUST
15. Birthplace Creeley Neb.
(City, town, or county) (State or foreign country)

16. (a) Informant John Adam Weeks

(b) Address West Plains Mo. R.F.D.

17. (a) Burial (b) Date thereof 4-4-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Homeland Cemetery

18. (a) Signature of funeral director Sexton Mary Ann

(b) Address West Plains Mo. R.F.D.

19. (a) 5-14-43 (b) Paul Hailer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd
year 1943 hour about 8 minute A.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 _____
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? _____

While at work? (Specify type of place) _____ (e) Means of injury _____
23. Signature Paul Hailer (M.D. or other) _____
Address West Plains Mo Date signed 5/14/43

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

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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. June Cr.
Registrar's No. 47

Registration District No. 141

Primary Registration District No. 5551

1. PLACE OF DEATH:
(a) County Naselle
(b) City or town West Plains
(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 14 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME John Dale Weeks
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 8

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

7. Birth date of deceased Dec. 29, 1929
(Month) (Day) (Year)

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

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

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Naselle
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April Day 3rd Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I met saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: I don't know
might be heart, as
it was a frail baby
from birth -
I think, very early
blue baby
Due to: _____
Other conditions (include pregnancy within 3 months of death) _____

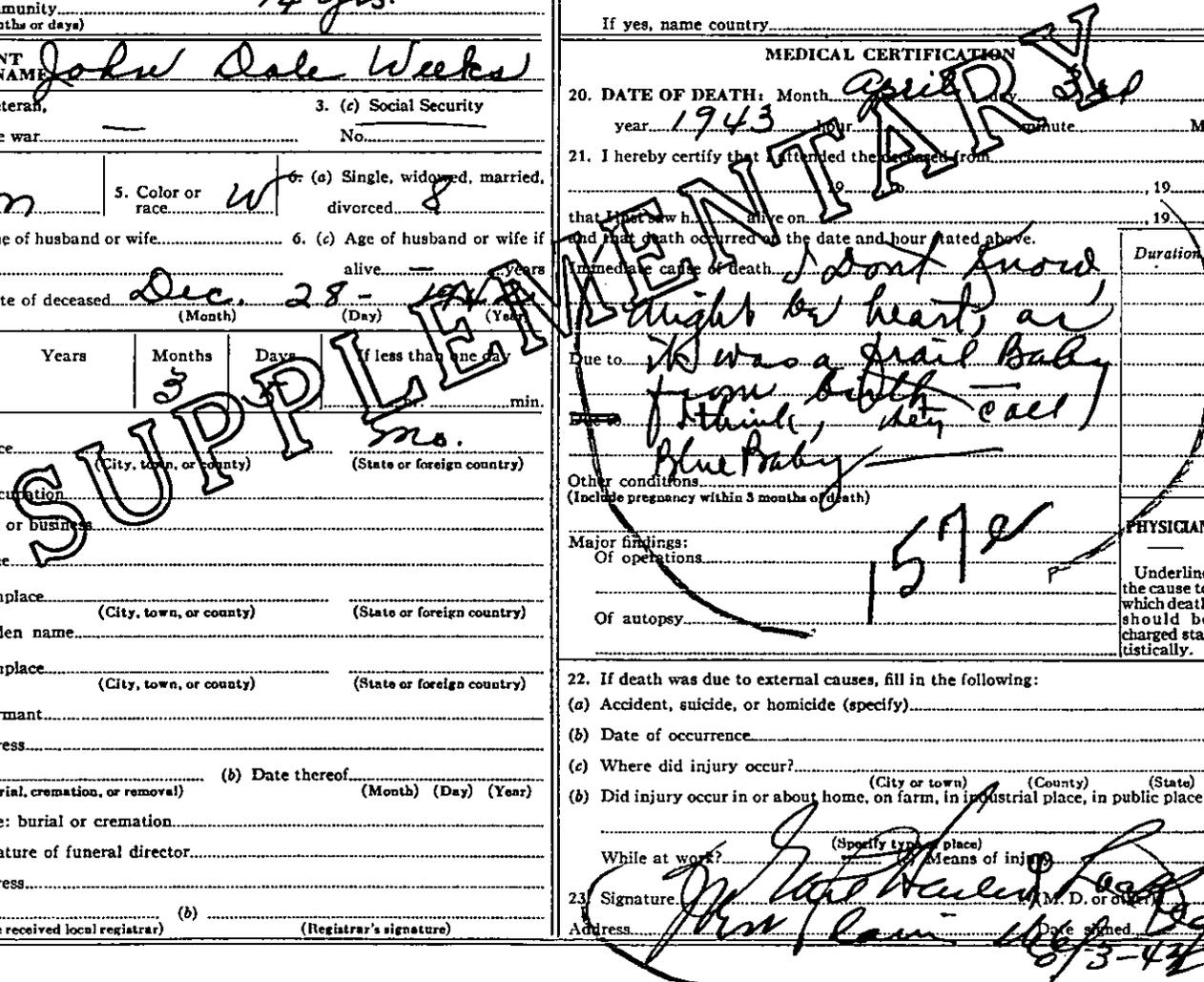
Major findings: _____
Of operations _____
Of autopsy _____

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
Means of injury _____
23. Signature Dr. Wm. W. Weeks M. D. or other _____
Address West Plains, Mo. Date signed 10/3-44

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

MOTHER FATHER



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

JUN 29 1943

S-18028