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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUL 24 1943

128
310

Registration District No. _____

Primary Registration District No. 5465

Registrar's No. 524

1. PLACE OF DEATH:

(a) County. **GREENE**

(b) City or town. **SPRINGFIELD Rural, N. Campbell**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **2640 N. DELAWARE**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. **67 YR. 4 MO. 23 DAYS**
In this community. **67 YR. 4 MO. 23 DAYS**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. **MO.** (b) County. **GREENE**

(c) City or town. **SPRINGFIELD Rural, N. Campbell**
(If outside city or town limits, write "RURAL")

(d) Street No. **2640 N. DELAWARE**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **EVELYN WEBER**

3. (b) If veteran, name war. **NONE**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1st**
year **1943** hour **3** minute **30 P.** M.

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced. **MARRIED**

6. (b) Name of husband or wife. **CHARLES WEBER**

6. (c) Age of husband or wife if alive. **73** years

7. Birth date of deceased. **FEB. 8 1876**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **3-20** 19**42** to **6-30** 19**43**
that I last saw **her** alive on **6-30-43** 19**43**
and that death occurred on the date and hour stated above.

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

67 **4** **23** hr. min.

Immediate cause of death
**Degenerative Heart Disease
& Auricular Fibrillation**

Due to **Bronchial Asthma**

Duration **2 yrs.**

9. Birthplace **GREENE CO. MO. 0**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

10. Usual occupation **House wife**

11. Industry or business **In home**

12. Name **Billy Price**

13. Birthplace **GREENE Co. MO. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Harriet Roberts**

15. Birthplace **unk. MO. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Weber**

(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **7-3-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellevue Cem.**

18. (a) Signature of funeral director. **J. W. Klingner & Co.**

(b) Address **SPRINGFIELD MO.**

19. (a) **7-3-43** (b) **J. W. Handley**
(Date received local registrar) (Registrar's signature)

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? **NO** (Specify type of place) (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) _____

Address **Springfield, Mo.** Date signed **7-1-43**

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

MOTHER FATHER

944

W

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 Roy A. Leavins
Licensed Embalmer No. 1763
P. O. Address Springfield 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.

X