

0-2  
5-43  
17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 10 1944  
144

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1817  
Registrar's No. 350

Registration District No. 144  
Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Trinity Lutheran  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community 52 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1023 Askew  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME ROBERT JAMES WEAVER

3. (b) If veteran, name war No  
3. (c) Social Security No. None 492-26-243

4. Sex Male  
5. Color or Race White  
6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Mary Jane  
6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased March 17, 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 10 2  
hr. min.

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

10. Usual occupation Retired Paving Contractor

11. Industry or business Self

12. Name Jos. Weaver

13. Birthplace Pa.  
(City, town, or county) (State or foreign country)

14. Maiden name Isabella Johnston  
(City, town, or county) (State or foreign country)

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Gertrude Weaver

(b) Address 409 E. Armour

17. (a) Burial (b) Date thereof 1/21/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.  
(b) Address Kansas City, Mo.

19. (a) Jan 21, 1944 F. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19  
year 1944 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Dec 10 1943 to Jan 18 1944  
that I last saw him alive on Jan 18 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia 2 days

Due to Infection

Due to

Other conditions Chronic Myocarditis  
(Include pregnancy within months of death)  
Chronic Mitral Regurgitation

Major findings:  
Of operations

Of autopsy 93d

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?

(Specify type of place)  
C. While at work? (e) Means of injury 0

23. Signature Harry W. Dwyer (M. D. or other)  
Address 1401 Prospect Date signed 1-21-44

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

MOTHER, FATHER

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

Dr. L. W. Gray  
1401 Broadway

**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..... *H. O. Blackman*

Licensed Embalmer No. *3639*

P. O. Address..... *N. E. 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.