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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 7 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 139

Primary Registration District No. 4775

Registrar's No. 76

1. PLACE OF DEATH:

(a) County Holt

(b) City or town Forest City
(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 20 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED: 44

(a) State Missouri (b) County Holt

(c) City or town Forest City
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Mary Catherine Wieman

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1944 hour 3:30 minute _____ P. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William H. Wieman 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased November 26 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from FEB. 11, 44 to MAY 7 1944 that I last saw her alive on MAY 6 1944 and that death occurred on the date, and hour stated above.

8. AGE: Years 82 Months 3 Days 10 If less than one day hr. _____ min.

Immediate cause of death ALP. STAT. PNEUMONIA Duration 4 DAYS

9. Birthplace Holt County Missouri
(City, town, or county) (State or foreign country)

Due to SENILITY

10. Usual occupation At home

Due to _____

11. Industry or business _____

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

MOTHER FATHER

12. Name Daniel Thornton

13. Birthplace DeKalb County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Emery

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

Major findings: Of operations _____ Of autopsy _____

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

16. (a) Informant Mr. Bert Smith (b) Address Oregon, Missouri

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Mar. 9 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OREGON, Mo

(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? _____

18. (a) Signature of funeral director James H. Pitts

(b) Address Oregon, Mo.

19. (a) 3-9-44 (b) Pauline Dawson
(Data received local registrar) (Registrar's signature)

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

23: Signature Dr. Howard Colburn (M.D. or other) D.O.
Address Forest City, Mo. Date signed MAY 9 1944

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.....

James B. Pettigrove

Licensed Embalmer No.....

3192

P. O. Address.....

Oregon 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.

Registration District No. 129

Primary Registration District No. 4224

1. PLACE OF DEATH:

(a) County Holt
(b) City or town Forest City
(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)

3. (a) PRINT FULL NAME Mary Catherine Weeman

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

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

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

7. Birth date of deceased Nov 26
(Month) (Day) (Year)

8. AGE: Years 82 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 _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day _____ Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pulmonary emphysema (BRONCHIAL) 107 days

Due to Senility

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

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