

5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17408**

FILED MAY 16 1945

Primary Registration District No. **5704**

Registrar's No. **4**

59
0
0
0
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Wheeling
(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 3 weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn **58**

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

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

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME Frankie Belle Jones

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 27
year 1945 hour 10:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to APRIL 27, 1945
that I last saw h.e.r. alive on APRIL 27 — 1945
and that death occurred on the date and hour stated above.

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife John W. Jones

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased: Sept 30 1868
(Month) (Day) (Year)

Immediate cause of death

MYOCARDIAL FAILURE
HYPERTENSION
PULMONARY EDEMA
CHRONIC NEPHRITIS

Due to _____

Due to _____

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

8. AGE: Years 76 Months 6 Days 27
If less than one day _____ hr. _____ min.

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

Major findings: Of operations _____

Of autopsy 131A

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob Weidenhammer

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

14. Maiden name Sarrah Heart

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

16. (a) Informant Walter Weiden

(b) Address Meadville, Mo

17. (a) Burial (b) Date thereof Apr 29 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meadville cemetery

18. (a) Signature of funeral director Smiley Funeral Home

(b) Address Wheeling Mo

19. (a) 4/28/45 (b) Paul J. Norman
(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?
(Specify type of place)

While at work? _____ (e) Means of injury 2

23. Signature S. W. Hanson (M. D. or other) D.D.
Address Meadville Mo Date signed 4-28-45

RECEIVED
District Health Officer No. 111
District File Number
Date Filed

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 self

Registered Apprentice No. _____

working under my personal supervision.

Signed Frank S Smiley

Licensed Embalmer No. 470

P. O. Address Wheeling 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.