

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Blairtown  
(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 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Aloysius Weess

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 Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased 11-27-1867  
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 13 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown  
13. Birthplace " 4  
(City, town, or county) (State or foreign country)  
14. Maiden name "  
15. Birthplace " 4  
(City, town, or county) (State or foreign country)

16. (a) Informant John Weess

(b) Address Blairtown Mo

17. (a) Burial (b) Date thereof 8-13-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eaglewood

18. (a) Signature of funeral director Fred Weess

(b) Address Clinton Mo

19. (a) 8/13 (b) Myrtle Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry  
(c) City or town Blairtown  
(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 8 day 10  
year 1945 hour 7:20 minute PM

21. I hereby certify that I attended the deceased from Aug 10  
1945 to Aug 10 1945  
that I last saw him alive on Aug 10  
and that death occurred on the date and hour stated above.

Immediate cause of death perforated ulcer

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
153:2

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 2

23. Signature E. N. Robinson (M.D. or other)

Address Chilhowee Mo Date signed \_\_\_\_\_

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

RECEIVED  
District Issued Officer No. 7,  
District File Number 8-45-900  
Date Filed 9-6-43

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 Frederick Wilkerson

Licensed Embalmer No. 2478

P. O. Address Clinton 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.