

FILED AUG 20 1945

State File No. \_\_\_\_\_

Registration District No. 160

Primary Registration District No. 3030

Registrar's No. 209

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

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Festus  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson

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

(d) Street No. 614 8th St  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John H. Weathers

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22<sup>d</sup>  
year 1945 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from May 15 to July 2, 1945  
that I last saw him alive on July 2, 1945  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Francis Weathers 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased: Oct. 10 1870  
(Month) (Day) (Year)

Immediate cause of death Cerebral Apoplexy Duration 1 mo

Due to Hypertension + Atherosclerosis

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

8. AGE: Years 74 Months 8 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Crawford Co., Ind.  
(City, town, or county) (State or foreign country)

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

10. Usual occupation Retired

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

12. Name John S. Weathers

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

14. Maiden name Sarah Taylor

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

Major findings: Of operations \_\_\_\_\_ Of autopsy 83a

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

16. (a) Informant Ms Francis Weathers

(b) Address Festus Mo

17. (a) Burial (b) Date thereof 7-4-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Lawn Mem. Park

18. (a) Signature of funeral director Frank Ind. Co.

(b) Address Festus Mo

19. (a) July 2, 1945 (b) Virginia Gilliam, D.P.  
(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 \_\_\_\_\_

23. Signature James M. D. D. or other \_\_\_\_\_  
Address Capital City Mo Date signed July 21 1945

1359

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

*8-17-45*

**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 \_\_\_\_\_

*Eleana Province*

Licensed Embalmer No. \_\_\_\_\_

*3403*

P. O. Address \_\_\_\_\_

*Jessie Ms*

**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.**