No. ___
--2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 9 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14228

Registration District No. 316 | Primary Registration District No. 3060 | Registrar's No. 136

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington, (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 78 years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 94

(a) State Missouri (b) County St. Francois

(c) City or town Farmington 4 (If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country ___

3. (a) PRINT FULL NAME Lucinda Williams Weimer

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 W 2

6. (b) Name of husband or wife Charles C. Weimer 6. (c) Age of husband or wife if alive ___ years

7. Birth date of deceased August 10 1867 (Month) (Day) (Year)

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

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

10. Usual occupation housewife

11. Industry or business ___

FATHER
12. Name Gardner Williams 9
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine Williams
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Walter Weimer

(b) Address Centerville Station Ill.

17. (a) b (Burial, cremation, or removal) (b) Date thereof 4-23-46 (Month) (Day) (Year)

(c) Place: burial or cremation k of p. of Farmington

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farmington, Mo.

19. (a) 4/19/46 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18 year 1946 hour 9 minute 15 a.m.

21. I hereby certify that I attended the deceased from Jan. ___, 1946 to April 18, 1946 that I last saw her alive on April 17, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cancer of Lung.	2 mo
Due to Cancer of Left Breast	5 years
Due to	
Other conditions (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations Had X-Ray Treatment in Feb. 1946 for Left Breast

Of autopsy None

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? ___ (Specify type of place) 5

While at work? ___ (e) Means of injury ___

23. Signature L. M. Stanfield (M. D. or other) DO

Address Farmington Mo. Date signed 4/19/46

289 (Licensed Embalmer's Statement on Reverse Side)

D

District Health Officer No. 4
District File Number 546-209
Date Filed 5-8-46

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 .....

Licensed Embalmer No. 4087

P. O. Address Farmington

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.

No. 2B
—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 136

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Farmington
(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 ..... (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 .....

3. (a) PRINT FULL NAME Lucinda W. Weimer

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 Wid

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Aug (Month) 10 (Day) 86 (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April 18
year 1946 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... , 19..... to ..... , 19.....;
that I last saw h..... alive on ..... , 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Left Breast	unknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy 50

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature M Stanfield (M. D. or other)
Address Farmington Date signed .....

SUPPLEMENTARY

13128

14228