

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29417**

FILED SEP 14 1946

Primary Registration District No. **4530**

Registrar's No. **36**

1. PLACE OF DEATH

(a) County **Worth**
(b) City or town **Sheridan Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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

Chara Weese

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 **Widowed**
6. (b) Name of husband or wife **Ben Weese** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 18 1877** (Month) (Day) (Year)

8. AGE: Years **69** Months **11** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Sheridan Missouri** (City, town or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **"**

12. Name **Albiness & Black**

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

14. Maiden name **Lucy Ann Buck**

15. Birthplace **Crawford Indiana** (City, town or county) (State or foreign country)

16. (a) Informant **Charles Black**

(b) Address **Creston Iowa**

17. (a) **Cremation** (b) Date thereof **Sept 1 - 1946** (Month) (Day) (Year)

(c) Place: burial or cremation **Logans Cemetery**

18. (a) Signature of funeral director **John Andrews**

(b) Address **Grant City Missouri**

19. (a) **Sept 3, 1946** (b) **Letitia Dawson** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Worth**
(c) City or town **Sheridan Missouri** (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **29** year **1946** hour **200** minute **8** M.

21. I hereby certify that I attended the deceased from **Aug 27**, 1946, to **Aug 29**, 1946, and that I last saw him alive on **Aug 28**, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death **Suffered Sudden** Duration **3 days**

Due to _____

Due to _____

Other conditions **✓** (Include pregnancy within 3 months of death)

Major findings: Of operations **94%**

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 **John Andrews** (M.D. or other)

Address **Grant City Mo** Date signed **Aug 30 46**

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

282394

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

John Andrews Jr......, Registered Apprentice No.....
working under my personal supervision.

Signed.....John Andrews Jr......

Licensed Embalmer No. 4211.....

P. O. Address Grant City.....

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.