

FILED APR 10 1947

Registration District No. 370

Primary Registration District No. 6080

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Ste. Genevieve

(b) City or town Saline Twp.
(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 Life time
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ste Genevieve

(c) City or town Rural
(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 _____

3. (a) PRINT FULL NAME Russell Oscar De Weez

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 W 21

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Oscar De Weez

13. Birthplace Mo. (State or foreign country)

14. Maiden name Fannie Calvert

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

16. (a) Informant Ted De Weez

(b) Address Farmington, Mo. Rt. #3

17. (a) B. (b) Date thereof 4 4 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park View Cem.

18. (a) Signature of funeral director Cozzen Funeral Home Farmington, Mo.

(b) Address _____

19. (a) 4-5-47 (b) Hester N. Karl
(Date received local certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 year 47 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 1945 to April 1 1947
that I last saw him alive on April 1 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia lobar not specified. Duration 2 wks

Due to Non specified.

Due to _____

Other conditions Pneumonia (Include pregnancy within 3 months of death) 4 wks.

Major findings: Of operations _____

Of autopsy 106

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 1

23. Signature A. J. ... (M. D. or other) Med.

Address Farmington, Mo. Date signed 4-2-47

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

5
0
0

35-0

JUN 17 1947

RECEIVED

District Health Officer No. 4

District File Number 447-513

Date Filed 4-9-47

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 M. E.

....., Registered Apprentice No.
working under my personal supervision.

Signed Nellie Harter

Licensed Embalmer No. 2969

P. O. Address Farmington 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.