

FILED OCT 16/1947  
Registration District No. **116**

Primary Registration District No. **3020**

Registrar's No. **129**

1. PLACE OF DEATH:

(a) County **Franklin**  
(b) City or town **Washington**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **St. Francis Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 day**  
In this community **1 day**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**  
(c) City or town **Washington "Rural"**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **R. #1 E.**  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **3rd**  
year **1947** hour **4:00** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Oct 2-47**  
19 **Oct 3, 47** 19  
that I last saw him alive on **Oct 3, 47** 19  
and that death occurred on the date and hour stated above.

Immediate cause of death **Convulsions**  
**of unknown origin -**  
**Exempt from 8 hrs.**  
Due to **mother has an acute**  
**nephritis.**  
Due to \_\_\_\_\_

Duration

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **59**  
Of autopsy \_\_\_\_\_  
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)  
(c) Means of injury \_\_\_\_\_  
23. Signature **[Signature]** (M. D. or other)  
Address **Washington Mo** Date signed **10/4/47**

3. (a) PRINT FULL NAME **Teresa Weber.**

3. (b) If veteran, name war **X** 3. (c) Social Security No. **X**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive **X** years

7. Birth date of deceased **October 2nd, 1947.**  
(Month) (Day) (Year)

8. AGE: Years **0** Months **0** Days **1**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **X**

11. Industry or business **X**

12. Name **Edmund A. Weber.**

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

14. Maiden name **Frances A. Kuenzel.**

15. Birthplace **Villa Ridge, Missouri.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Edmund A. Weber**

(b) Address **Washington, Mo. R. #1 E.**

17. (a) **Burial** (b) Date thereof **Oct. 4, 1947.**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington, Mo.**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Washington, Mo.**

19. (a) **OCT 4 1947** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

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

16  
6  
2

36  
0  
3  
0

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed OCT 15 1947

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.....

*Jerome L. Swohoda*, Registered Apprentice No. *444*  
working under my personal supervision.

Signed *Lester A. Vitt*

Licensed Embalmer No. *3254*

P. O. Address *Washington, 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.**