

S. No. 30  
M-10-47  
v. 5-17-39  
I 3906

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED APR 17 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 112955  
Registrar's No. 1422

Registration District No. 949

Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 1/2 hrs.  
In this community 2 years 11 months 20 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ted Lee Weaver  
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 10, 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 11 20 hr. min.

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

10. Usual occupation child

11. Industry or business \_\_\_\_\_  
12. Name Wallace Weaver  
13. Birthplace Caldwell Co., Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Mildred Kinne  
15. Birthplace Caldwell Co., Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Wallace Weaver  
(b) Address 7218 Indiana

17. (a) Removal (b) Date thereof 3-31-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Hamilton Mo

18. (a) Signature of funeral director Bram Brunel  
(b) Address Hamilton Mo

19. (a) 3-31-48 (b) Stearline Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7218 Indiana  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 30  
year 1948 hour 9 minute 30 P.A.M.  
21. I hereby certify that I attended the deceased from March 30, 1948 to March 30, 1948,  
that I last saw him alive on March 30, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia-Malnutrition  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions 107  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy See above  
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) (e) Means of injury \_\_\_\_\_  
23. Signature Wm W. Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 3-31-48

*Dr. Williams*

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**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..... *R. Lester Bram*.....

Licensed Embalmer No..... *7472*.....

P. O. Address..... *Hamilton 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.**