

No. 300  
1-10-47  
5-17-39  
11-25-06

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED SEP 2 1948

Registration District No. 273

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28726

Primary Registration District No. 6268

Registrar's No. 42

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

1. PLACE OF DEATH:

(a) County Webster  
(b) City or town Rural-Mianqua township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: x 9  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution x (Specify whether)  
In this community life years, months or days

3: (a) PRINT FULL NAME Elijah Weeks  
3: (b) If veteran, name war x  
3: (c) Social Security No. x

4. Sex male 5. Color or race white  
6: (a) Single, widowed, married, divorced married  
6: (b) Name of husband or wife Nancy Weeks  
6: (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased July - 15 - 1874  
(Month) (Day) (Year)

8. AGE: Years 74 Months no Days 28  
If less than one day x hr. x min.

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

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER

12. Name William Weeks

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

14. Maiden name Nancy Carpenter

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

16: (a) Informant Mrs. Nancy Weeks

(b) Address #1 Conway, Missouri

17: (a) Burial (b) Date thereof 8-15-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Had spring

18: (a) Signature of funeral director [Signature]

(b) Address Marshfield, Mo

19: (a) 8/18/48 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Webster  
(c) City or town Conway R.F.D #1  
(If outside city or town limits, write "RURAL")  
(d) Street No. Conway R.F.D #1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ A.M.  
21. I hereby certify that I attended the deceased from July 14-1948  
to Aug. 11 1948.  
that I last saw him alive on Aug. 11 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Colloidal degeneration of generalised interstitial  
Duration \_\_\_\_\_

Due to Duration unknown

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: None 55 E ADDITIONAL  
- Of operations \_\_\_\_\_

Of autopsy None SUPPLEMENTAL  
\_\_\_\_\_ INFORMAT

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) \_\_\_\_\_ (Means of injury)

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Mianqua, Mo Date signed 18 Aug 48

RECEIVED

District Health Officer No. 6,

District File Number 848-961

Date Filed AUG 31 1948

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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 *Her [Signature]*

Licensed Embalmer No. 3312

P. O. Address *Marshfield 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.