

FILED MAR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7271

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 88

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>	
c. LENGTH OF STAY (in this place) <u>2 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>108 - E. Harrison</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Jacob</u> b. (Middle) <u>William</u> c. (Last) <u>Weaver</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3 28 1949</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>6-4-1863</u>		9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>concrete Const.</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>JAMES Weaver</u>		13b. MOTHER'S MAIDEN NAME <u>EDITH PRITCHARD</u>		14. NAME OF HUSBAND OR WIFE <u>ANNALIVE Weaver</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Paul WARRICK</u>	
				ADDRESS <u>5110 King Hill, St Joseph, Mo</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sepsis</u>		DUPLICATE TO (b) <u>gangrene of foot</u>				DUPLICATE TO (c) <u>Generalized arteriosclerosis</u>	
ANTECEDENT CAUSES		DUPLICATE TO (b) <u>gangrene of foot</u>				DUPLICATE TO (c) <u>Generalized arteriosclerosis</u>	
II. OTHER SIGNIFICANT CONDITIONS		DUPLICATE TO (b) <u>gangrene of foot</u>				DUPLICATE TO (c) <u>Generalized arteriosclerosis</u>	
DUPLICATE TO (b) <u>gangrene of foot</u>		DUPLICATE TO (c) <u>Generalized arteriosclerosis</u>				DUPLICATE TO (d) <u>3 weeks</u>	
DUPLICATE TO (b) <u>gangrene of foot</u>		DUPLICATE TO (c) <u>Generalized arteriosclerosis</u>				DUPLICATE TO (d) <u>years</u>	
DUPLICATE TO (b) <u>gangrene of foot</u>		DUPLICATE TO (c) <u>Generalized arteriosclerosis</u>				DUPLICATE TO (d) <u>years</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4501</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Feb 2, 1947, to March 16, 1949, that I last saw the deceased alive on March 25, 1949, and that death occurred at 7 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>M.T. Gutenshuh D.O.</u>		23b. ADDRESS <u>Kirksville</u>		23c. DATE SIGNED <u>3-26-49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3-28-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Prough Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo. MO-PR</u>	
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DATE REC'D BY LOCAL REG. <u>3-26-49</u>		REGISTRAR'S SIGNATURE <u>Walter Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Spivey</u>		ADDRESS <u>Lawrence Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 1

District File Number 3.49.5

Date Filed MAR 29 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Louis E. Hopper

Signed _____
Student Embalmer

Licensed Embalmer No. 42061

P. O. Address Lawrence, 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.