

FILED APR 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14120

State File No.

BIRTH NO. _____ REG. DIST. NO. 280 PRIMARY REG. DIST. NO. 4498 Registrar's No. 22

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| 1. PLACE OF DEATH a. COUNTY <u>Platte</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Weston</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Weston</u> | |
| c. LENGTH OF STAY (in this place) <u>Weston</u> | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | |

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|--|-------------|--------------------------|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Jacob</u> | b. (Middle) | c. (Last) <u>Whallon</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>3-28-50</u> |
|--|-------------|--------------------------|---|

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|--------------------|-------------------------------|---|----------------------------------|---|--------------------------------|--------------------------------|
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u> | 8. DATE OF BIRTH <u>12-31-71</u> | 9. AGE (In years last birthday) <u>78</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|--------------------|-------------------------------|---|----------------------------------|---|--------------------------------|--------------------------------|

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|---|---|---|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u> | 11. BIRTHPLACE (State or foreign country) <u>Ind. Indiana</u> | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|------------------------------|

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|--|---|---------------------------------------|
| 13a. FATHER'S NAME <u>John Whallon</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Jane Estill</u> | 14. NAME OF HUSBAND OR WIFE <u>XX</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. W. W. Woodruff</u> ADDRESS <u>Weston, Mo.</u> |
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| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> | | <u>1 year</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Influenza & virus pneumonia</u> | | <u>4 weeks</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatitis, cystitis, retention of urine & urosepsis</u> | | <u>480X</u> | |
| | | <u>6 month</u> | |

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|-----------------------------------|--|--|
| 19a. DATE OF OPERATION <u>XXX</u> | 19b. MAJOR FINDINGS OF OPERATION <u>XXXXX None</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| | | |
|---|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>XXXX</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>XXXX</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Weston Platte Missouri</u> |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>XXXXXX</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>XXXX</u> |

22. I hereby certify that I attended the deceased from Jan. 2, 1950, to March 28, 1950, that I last saw the deceased alive on March 26, 1950, and that death occurred at 6 A m., from the causes and on the date stated above.

| | | |
|---|-------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Lewis C. Oberholtzer M.D.</u> | 23b. ADDRESS <u>Weston Missouri</u> | 23c. DATE SIGNED <u>3/29/50</u> |
|---|-------------------------------------|---------------------------------|

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|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>3-30-50</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Weston Mo.</u> |
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|---|--|--|
| DATE REC'D BY LOCAL REG. <u>2-29-50</u> | REGISTRAR'S SIGNATURE <u>Alphie Rocina</u> | 25. FUNERAL DIRECTOR'S SIGNATURE (Address) <u>VAUGHN FUNERAL HOME WESTON MO.</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED APR 5

District Health Officer No. 8,

District File Number _____

Date Filed 4-18-50

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.

Student _____
Student Embalmer

Signed

W. R. Vaughn

Licensed Embalmer No.

4023

P. O. Address

Winston, Md.

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.