

FILED SEP 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30066

State File No.

No. 300

10.48

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>819</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		0396 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>2337 N. PROSPECT</u>				d. STREET ADDRESS (If rural, give location) <u>2337 N. PROSPECT</u>			
3. NAME OF DECEASED (Type or Print)			a. (First) <u>MAX</u>	b. (Middle) <u>R.</u>	c. (Last) <u>WEBER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 16 1950</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>6 JAN. 1860</u>	
9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 HRS. Hours Min.	
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>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>HUMAN WEBER</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>KATE WEBER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME <u>KATE WEBER</u>		ADDRESS <u>SPGFD. 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Metastatic Cancer of Lung</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Cancer of Lip</u> DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						<u>140X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Sept 16</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>50</u> , and that death occurred at <u>8:45 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Max Hitt</u>		23b. ADDRESS <u>M.D. Springfield Mo</u>		23c. DATE SIGNED <u>9-17-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>9-18-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN CEME.</u>		24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-19-50</u>		REGISTRAR'S SIGNATURE <u>W.G. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Klingner & Co.</u>		ADDRESS <u>Spfld. Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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

Max Rhodes

Licensed Embalmer No. _____

4071

P. O. Address _____

Springfield

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.