

BIRTH NO. 2960-51 REG. DIST. NO. 362 PRIMARY REG. DIST. NO. 4531 Registrar's No. #1

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

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Warren | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Montgomery | |
| b. CITY (If outside corporate limits, write RURAL and give township) WATERFORD | | c. CITY (If outside corporate limits, write RURAL and give township) Rural | |
| c. LENGTH OF STAY (In this place) | | d. STREET ADDRESS (If rural, give location) none | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION MacRae Hospital | | | |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Sharon Kay b. (Middle) Weant c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) I-6-51 | | |
|--|--|--|--|--|--|

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|--------------------|------------------------------|--|-----------------------------------|---------------------------------|---------------------------|--------------------------|--------------------------|
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S | 8. DATE OF BIRTH I-5-51 | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | IF UNDER 6 HRS. Hours | IF UNDER 15 MIN. Min. |
|--------------------|------------------------------|--|-----------------------------------|---------------------------------|---------------------------|--------------------------|--------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | 10b. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (State or foreign country) Montgomery | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME William Weant | 13b. MOTHER'S MAIDEN NAME Bettie Pride | 14. NAME OF HUSBAND OR WIFE S |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. no | 17. INFORMANT'S SIGNATURE OR NAME William Weant | ADDRESS New Florence Mo |
|---|--------------------------------------|---|-----------------------------------|

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Atelectasis | | INTERVAL BETWEEN ONSET AND DEATH (14 hrs) 7620 |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (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 Jan. 5, 1951 to Jan. 6, 1951, that I last saw the deceased alive on Jan. 5, 1951, and that death occurred at 5 A.M. from the causes and on the date stated above.

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|--|--|-----------------------------------|
| 23a. SIGNATURE (Degree or title) <i>[Signature]</i> | 23b. ADDRESS Box 347 New Florence, Mo. | 23c. DATE SIGNED 1/6/51 |
|--|--|-----------------------------------|

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|---|----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) B | 24b. DATE I-7-51 | 24c. NAME OF CEMETERY OR CREMATORY Montgomery City Cem | 24d. LOCATION (City, town, or county) (State) Montgomery City Mo |
|---|----------------------------|--|--|

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|--|---|--|---------|
| DATE REC'D BY LOCAL REG. 1-19-51 | REGISTRAR'S SIGNATURE <i>[Signature]</i> | 25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> | ADDRESS |
|--|---|--|---------|

File No. _____
DISTRICT HEALTH OFFICE NO. 4

JAN 24 1951

RECEIVED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed _____

Student Embalmer

Licensed Embalmer No.

P. O. Address _____

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.