

FILED FEB 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7213

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>SIKESTON</u>		c. LENGTH OF STAY (in this place) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>111 E KATHLEEN</u>		d. STREET ADDRESS (If rural, give location) <u>111 E KATHLEEN</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>GUY</u> b. (Middle) <u>RUSSELL</u> c. (Last) <u>WEEKLEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-26-51</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>FEB 22 1902</u>
9. AGE (in years last birthday) <u>48</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MGR PICTURE THEATER</u>	11. BIRTHPLACE (State or foreign country) <u>SIKESTON MO</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MGR PICTURE THEATER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MOVIES</u>	12. CITIZEN OF WHAT COUNTRY? _____
13a. FATHER'S NAME <u>JESSIE R WEEKLEY</u>		13b. MOTHER'S MAIDEN NAME <u>MARYETTA HOLLAND</u>	14. NAME OF HUSBAND OR WIFE <u>BERNICE</u>
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>497-05-2318</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Bernice Weekley - Sikeston Mo</u> ADDRESS _____
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		_____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		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>1-26</u> , 19 <u>51</u> , to <u>1-26</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1-26</u> , 19 <u>51</u> , and that death occurred at <u>11:30 A.</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>E. S. Urban, M.D.</u> (Degree or title) _____		23b. ADDRESS <u>Sikeston</u>	
23c. DATE SIGNED <u>2-2-51</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>1-28-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	
24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Funeral Home - Sikeston Mo</u> ADDRESS _____	
DATE REC'D BY LOCAL REG. <u>Feb 9-51</u>		REGISTRAR'S SIGNATURE <u>Mrs Ella Huntley</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48

2024 9 10

RECEIVED FEB 12 1951

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 251-47

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sixteen 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.