

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **6460**

BIRTH NO.		REG. DIST. NO. 146	PRIMARY REG. DIST. NO. 3026	Registrar's No. 64
1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY OR TOWN Independence	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Independence (Blue)		
d. FULL NAME OF HOSPITAL OR INSTITUTION Indep. Sanitarium		d. STREET ADDRESS Rt. 2 - Box 405 - 24 Highway		
3. NAME OF DECEASED a. (First) Nellie		b. (Middle) M.	c. (Last) Weeks	
4. DATE OF DEATH (Month) (Day) (Year) Jan. 27, 1953				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 1 1897	9. AGE (in years last birthday) 55 Months 3 Days 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) North Platt Nebraska
12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME W.A. Stoddard		13b. MOTHER'S MAIDEN NAME Mary Godfrey		14. NAME OF HUSBAND OR WIFE Frank Weeks
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Frank Weeks ADDRESS Indep
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage (mainly) INTERVAL BETWEEN ONSET AND DEATH 12 hrs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular disease years DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 443X		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)		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 7/24, 1951 , to 1/27, 1953 , that I last saw the deceased alive on 1/27, 1953 , and that death occurred at 12:10 PM. , from the causes and on the date stated above.				
23a. SIGNATURE Vance E. Link, MD (Degree or title)		23b. ADDRESS Independence, Mo		23c. DATE SIGNED 1/29/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 31-53	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Kansas City Mo
DATE REC'D BY LOCAL REG. 1-31-53		REGISTRAR'S SIGNATURE [Signature]		5. FUNERAL DIRECTOR'S SIGNATURE Poland R. Speake ADDRESS Indep

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

7005

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 Walter H. Hallemann

Licensed Embalmer No. 4627

P. O. Address Indep. 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.