

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21839**

FILED JUN 26 1953

REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 250

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 (If outside corporate limits, write RURAL and give township) OR TOWN Independence		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence	
d. FULL NAME OF HOSPITAL OR INSTITUTION 935 S. Liberty		d. STREET ADDRESS (If rural, give location) 935 S. Liberty	

3. NAME OF DECEASED (Type or Print) a. (First) MRS. BERNICE b. (Middle) HARRIS c. (Last) WEATHERFORD			4. DATE OF DEATH June 11, 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH July 26, 1887		9. AGE (In years last birthday) 65		IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0	
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) Buckner, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Charles R. Harris		13b. MOTHER'S MAIDEN NAME Harriett Duffield		14. NAME OF HUSBAND OR WIFE Chas. A. Weatherford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and date of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Chas. A. Weatherford Ond, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Multiple Myelomata			2 yrs 1 mo		
			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.								

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Sternal Puncture only		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) 203X	
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 **April 5, 1951**, to **June 12, 1953**, that I last saw the deceased alive on **June 12, 1953**, and that death occurred at **5:45 AM** from the causes and on the date stated above.

23a. SIGNATURE Carl Allen M.D. (Degree or title)		23b. ADDRESS Trust State Bank Independence, Mo.		23c. DATE SIGNED June 13/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 15, 1953		24c. NAME OF CEMETERY OR CREMATORY Woodlawn	
		24d. LOCATION (City, town, or county) (State) Indep, Mo.			

DATE REC'D BY LOCAL REG. 6-15-53		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Att. Mitchell Indep, Mo.	
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JUL 1

AUG 27 1959

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 m

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Henry S Mitchell

Licensed Embalmer No. 3925

P. O. Address Indy, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.