FILED NOV 6 - 1953

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 35407

BIRTH NO. _____ REG. DIST. NO. 80 PRIMARY REG. DIST. NO. 5306 Registrar's No. 19

**1. PLACE OF DEATH**
a. COUNTY: Cole - Marion Twp.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Martins
c. LENGTH OF STAY (in this place): 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 mile west on 50 Hiway

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Cole
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Martins 0260 0
d. STREET ADDRESS (If rural, give location): 1 mile west on Hi. 50.

**3. NAME OF DECEASED** (Type or Print)
a. (First): Julius
b. (Middle):
c. (Last): Weichbrodt

**4. DATE OF DEATH** (Month) (Day) (Year): Oct. 18-1953

**5. SEX**: Male 0
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Never Married
**8. DATE OF BIRTH**: June 3-1865
**9. AGE** (In years last birthday): 88 — If under 1 year: Months 4, Days 15 — If under 24 hrs.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Farmer
**10b. KIND OF BUSINESS OR INDUSTRY**: Farming
**11. BIRTHPLACE** (City and State or Foreign Country): Thorn, Germany 4
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Unknown
**13b. MOTHER'S MAIDEN NAME**: Unknown
**14. NAME OF HUSBAND OR WIFE**: None

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service): None
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S ~~SIGNATURE~~ OR NAME**: Mrs. Geneva McKinney — ADDRESS: J.C. Mo.

**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**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | CARDIAC DECOMPENSATION | 4 mos. |
| ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b) | ARTERIOSCLEROTIC HEART Disease | 10 yrs. |
| DUE TO (c) | Generalized Arteriosclerosis | 15 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* | Senility, Ascariasis | |

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**: 4200
**20. AUTOPSY?** YES ☐ NO ☒

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Aug. 10, 1953, *to* Aug. 10, 1953, *that I last saw the deceased alive on* Aug. 10, 1953, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): G. Donald Shull, M.D. 0
**23b. ADDRESS**: 521 E. High St., Jefferson City, Mo.
**23c. DATE SIGNED**: Oct. 25, '53

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: Oct. 20 1953
**24c. NAME OF CEMETERY OR CREMATORY**: St. Pauls
**24d. LOCATION** (City, town, or county) (State): Lohman Mo.

**DATE REC'D BY LOCAL REG.**: Nov. 2
**REGISTRAR'S SIGNATURE**: Mrs. Minnie Hettenmeyer 70-0
**25. FUNERAL DIRECTOR'S SIGNATURE**: [illegible] — ADDRESS: J.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

my-10-19-53

## 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 _____

Licensed Embalmer No. 3641

P. O. Address _____

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.