

BIRTH NO. 54119-54 REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 1372

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Laclede	
b. CITY (If outside corporate limits, write RURAL and give township) Lebanon		c. CITY (If outside corporate limits, write RURAL and give township) Lebanon	
c. LENGTH OF STAY (in this place) 1 Day		d. STREET ADDRESS (If rural, give location) Wallace Hospital	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wallace Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Baby Boy b. (Middle) None c. (Last) Weaver	4. DATE OF DEATH (Month) (Day) (Year) August 8, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, DIVORCED, WIDOWED (Specify) Never Married	8. DATE OF BIRTH August 7, 1954	9. AGE (In years last birthday) Months Days Hours Min. 1
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 (City and State or Foreign Country) Lebanon, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Not known	13b. MOTHER'S MAIDEN NAME Betty Ann Weaver	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE AND NAME Mrs. May Weaver Lebanon, Mo.	ADDRESS Lebanon, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis		30 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature birth 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"/>
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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) Lebanon, Missouri
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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
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22. I hereby certify that I attended the deceased from 8-7, 1954 to 8-8, 1954, that I last saw the deceased alive on 8-8, 1954, and that death occurred at 12:30 A., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. C. Carrington, M.D.	23b. ADDRESS Lebanon, Mo.	23c. DATE SIGNED 8-10-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-10-54	24c. NAME OF CEMETERY OR CREMATORY Roper Cemetery	24d. LOCATION (City, town, or county) (State) Laclede County Missouri
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DATE REC'D BY LOCAL REG. 8-10-1954	REGISTRAR'S SIGNATURE Hella L. Mayo	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS R. Palmer Jr. Lebanon, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Received AUG 21 1954
Laclede County Health Unit
File No. 8-54-128
Date Filed AUG 24 1954

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 _____

Working under my personal supervision
Not Embalmed
Student _____
Student Embalmer

Student Embalmer No. _____
Signed Stanley B. Palmer
Licensed Embalmer No. 4810
P. O. Address Shannon, 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.