

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25935

State File No.

FILED AUG 23 1955

BIRTH NO.		REG. DIST. NO. <u>139</u>	PRIMARY REG. DIST. NO. <u>4221</u>	Registrar's No. <u>64</u>
1. PLACE OF DEATH a. COUNTY <u>Holt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mound City</u>		c. LENGTH OF STAY (In this place) <u>83 yrs</u>	c. CITY OR TOWN <u>Mound City</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION.		e. STREET ADDRESS (If rural, give location) <u>0440</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>HUGH</u> c. (Last) <u>WEIGHTMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 18, 1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 7, 1871</u>	9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmers Mutual</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Mound City, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William Weightman</u> 13b. MOTHER'S MAIDEN NAME <u>Henrietta Noland</u> 14. NAME OF HUSBAND OR WIFE <u>Anne Eliza Weightman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>*****</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ray Weightman, Maryville, Mo.</u> ADDRESS
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) <u>Coronary Occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4201</u>		INTERVAL BETWEEN ONSET AND 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>7-3</u> , 19 <u>55</u> to <u>8-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-18</u> , 19 <u>55</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.				
23a. SIGNATURE <u>Dr. Perry M. D.</u> (Degree or title)		23b. ADDRESS <u>Mound City Mo.</u>		23c. DATE SIGNED <u>8-20-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/20/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Mound City, Missouri</u>
DATE REC'D BY LOCAL REG. <u>8-20-55</u>		REGISTRAR'S SIGNATURE <u>James H. Crawford</u> 469		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Crawford</u> ADDRESS <u>Mound City Mo.</u>

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *James Crawford*

Licensed Embalmer No... 479

P. O. Address *Norman Okla*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.