

FILED DEC 7 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38303

STATE FILE NUMBER

5031

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Ray				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Richmond, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp			Length of stay in 1b 52 days		d. STREET ADDRESS (If outside, give location) 405 E. LEXINGTON		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last WEIR				4. DATE OF DEATH Month 11 Day 20 Year 56				
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/1876	9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) L 9		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Weir				14. MOTHER'S MAIDEN NAME Amanda Reavis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 500-203475		17. INFORMANT Mrs. John Weir		Address Richmond		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from Cerebral Vessels DUE TO (b) Crisis of Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 10 days over 1 yr 5810		
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from 9/22/56 to 11/20/1956 and last saw him alive on 11/19/56 Death occurred at 1:00 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Robert W. Hamill MD (Degree or title)				22b. ADDRESS Kansas City, Mo.		22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, county) (State)				
24. FUNERAL DIRECTOR A. P. ...	ADDRESS	25. DATE RECD. BY LOCAL REG. 11-20-56		26. REGISTRAR'S SIGNATURE R. ...				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Robert W. Hamill

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

300
-56

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *E. J. Hummer*.....

Licensed Embalmer No. *90*.....

P. O. Address *Richm*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.