

FILED JAN 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41320

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5551 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Nowell</u>		2. USUAL RESIDENCE (Where deceased lived, or institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Nowell</u>	
b. CITY OR TOWN <u>West Plains</u> <small>(If outside corporate limits, write RURAL and give township)</small>	c. LENGTH OF STAY (In this place) <u>62 yrs</u>	c. CITY OR TOWN <u>West Plains</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rural</u>		e. STREET ADDRESS (If rural, give location) <u>Rte 2</u> <u>0460</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Beet</u> b. (Middle) <u>Lindell</u> c. (Last) <u>Weeks</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12/25/56</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>4/3-1894</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and State or Foreign Country) <u>West Plains Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Noah Weeks</u>	13b. MOTHER'S MAIDEN NAME <u>Florence Yuddard</u>	14. NAME OF HUSBAND OR WIFE <u>Sadie Weeks</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u></u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sadie Weeks West Plains Mo</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <small>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</small>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemiplegia - St following Cerebral Hemorrhage -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Mar 1950</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Auricular fibrillation</u> DUE TO (c) <u>Myocardial Damage Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS <small>Conditions contributing to the death but not related to the disease or condition causing death.</small>			

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) (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 2 Mar 1950 to 25 Dec 1956, that I last saw the deceased alive on 22-23 1956 and that death occurred at 7:20 m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>MD</u>	23b. ADDRESS <u>West Plains, Mo</u>	23c. DATE SIGNED <u>1-1-57</u>
24a. BURIAL, CREMATION, REBURYAL (Specify)	24b. DATE <u>12/28-29</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. New Liberty</u>	24d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>

DATE REC'D BY LOCAL REG. <u>1-4-57</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Koberstein West Plains Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

379
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100-111-111-111

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 *D. A. Roberts*

Licensed Embalmer No. *347*
P. O. Address *West Haven*

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.