

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026345  
STATE FILE NUMBER

FILED AUG 6 1958

Registration District No. 234

Primary Registration District No. 5816

Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richland Twn.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Rural Richland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>15 miles N.W. Stever</u>		Length of stay in lb <u>6 years</u>	d. STREET ADDRESS (If outside, give location) <u>15 miles N.W. of Stever</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Leo</u> Last <u>Weller</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 12 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>Pettis County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Conrad Weller</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Meyer</u>		14. NAME OF HUSBAND OR WIFE <u>Christina Weller</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>497-42-6150</u>		17. INFORMANT Address <u>Christina Weller Florence, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease 2-3 yrs</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>444X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>July 15</u> to <u>July 29</u> and last saw him alive on <u>July 21</u> Death occurred on <u>7:25 P.M.</u> on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ruth Kaufman, MD</u>			22b. ADDRESS <u>Missiles, Mo.</u>		22c. DATE SIGNED <u>7-31-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>August 1, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pettis County Missouri</u>
24. FUNERAL DIRECTOR <u>J. S. Johnson</u> ADDRESS <u>Stover, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Aug 2 1958</u>		26. REGISTRAR'S SIGNATURE <u>Wm L Ripberger</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 R. Scrimin* .....

Licensed Embalmer No. *4880* .....

P. O. Address *Vermont, Vt.* .....

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.