

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039393

STATE FILE NUMBER

FILED VS. DEC 3 1959 73

Primary Registration District No. 5291 Registrar's No. 131

MAILED

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|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY CLAY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY JACKSON | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LIBERTY | | Length of stay in 1b 6 WEEKS | | c. CITY OR TOWN KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ODD FELLOWS HOSPITAL | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4917 CENTRAL | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First John Middle T. Last Weckman | | | | 4. DATE OF DEATH Month 11 - Day 25 - Year 59 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 11-9-1878 | 9. AGE (last birthday) 81 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CASHIER | | 10b. KIND OF BUSINESS OR INDUSTRY ARMOR PACKING CO | | 11. BIRTHPLACE (City and state or country) KANSAS CITY, MO. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME JOHN WECKMAN | | 13b. MOTHER'S MAIDEN NAME WICKMAN FLORENCE FREE | | 14. NAME OF HUSBAND OR WIFE EDWARD WECKMAN EVA FREDERICK WECKMAN | | | |
| 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. 510-05-8492 | | 17. INFORMANT MRS. MILLER CRAVENS | | Address 4917 CENTRAL, K.C. MO. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Haemorrhage | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 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 _____ a.m. _____ p.m. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Oct 59 to Nov 25 and last saw him alive on Nov 24, 59 Death occurred at 7 A on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE W. H. Goodson (Degree or title) | | | | 22b. ADDRESS Liberty Mo | | 22c. DATE SIGNED 11/25-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 11-25-1959 | 23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEM. | | 23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO. | | | |
| 24. FUNERAL DIRECTOR ADDRESS FREEMAN MORTUARY KANSAS CITY MO. | | | 25. DATE RECD. BY LOCAL REG. 11-26-59 | | 26. REGISTRAR'S SIGNATURE Mabel Graham | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 18 1952

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 Clayton Barnes

Licensed Embalmer No. 4793

P. O. Address K. E., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.