

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 6 1960

354

6199

37

'59 0 46 5 8 3

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER _____

INDEXED

1. PLACE OF DEATH a. COUNTY Texas				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Texas									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clinton twp.		Length of stay in lb 45 yrs.		c. CITY OR TOWN Clinton twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5 mi. NW of Cabool			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rt. 2, Cabool		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First James Middle Fredrick Last Weaver				4. DATE OF DEATH Month 12 Day 25 Year 59									
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-30-1878		9. AGE (last birthday) 85		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) farming				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Hancock, Ill.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Samuel Weaver				13b. MOTHER'S MAIDEN NAME Clark				14. NAME OF HUSBAND OR WIFE Minnie Weaver					
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. none		17. INFORMANT Minnie Weaver, Cabool, Mo. Address _____							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH No known			
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 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 8-10-59 to 12-25-59 and last saw ^{her} him alive on 12-10-59 Death occurred at 6:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE [Signature] (Degree or title)				22b. ADDRESS Mountain Grove Mo				22c. DATE SIGNED 12-28-59					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12-27-59		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery				23d. LOCATION (City, town, or county) (State) Mt. Grove, Mo.					
24. FUNERAL DIRECTOR Elliott-Gentry Funeral Home, Cabool, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 12-29-59		26. REGISTRAR'S SIGNATURE [Signature]					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS NOV 9 1960

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 L. Kenty

Licensed Embalmer No. 4718
P. O. Address Calver, W.

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.