

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000544

FILED VS. FEB 3 1960 47

Registration District No. _____ Primary Registration District No. **3008** Registrar's No. **25**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY CALLAWAY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY SHELBY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FULTON		Length of stay in 1b 2Y, 1M, 18D		c. CITY OR TOWN SHELBY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSPITAL NO. 1			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) WASHBURN REST HOME			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First GEORGE Middle _____ Last WEISENBORN				4. DATE OF DEATH Month Jan Day 29 Year 1960									
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 1-7-1893		9. AGE (last birthday) 65		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY Unknown			11. BIRTHPLACE (City and state or country) CLARENCE, MISSOURI			12. CITIZEN OF WHAT COUNTRY U.S.A.				
13a. FATHER'S NAME GEORGE WEISENBORN				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address STATE HOSPITAL NO. 1, FULTON, 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) Lung, left - bronchopneumonia										INTERVAL BETWEEN ONSET AND DEATH 5d.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Brain Syndrome										2 years			
DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Decubitus Ulcers, many										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 St. Hosp.			COUNTY _____		STATE _____		
21. Attended the deceased from 12-11-1957			7:20P.M.			and last saw her/him alive on Jan. 29, 1960			on Jan 29, 1960				
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE J. Jackson MD (Degree or title)						22b. ADDRESS State Hospital No. 1				22c. DATE SIGNED 1/29/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Remove		23b. DATE Jan-30-1960		23c. NAME OF CEMETERY OR CREMATORY Clarence				23d. LOCATION (City, town, or county) (State) Mo.					
24. FUNERAL DIRECTOR Wallace Funeral Home, Fulton				ADDRESS _____		25. DATE RECD. BY LOCAL REG. Jan. 30 - 1960		26. REGISTRAR'S SIGNATURE Maretha Lawrence					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *A. P. Massey*

Licensed Embalmer No. 499

P. O. Address Fulton

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