

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027877

FILED VS AUG 1 0 1960

STATE FILE NUMBER

Registration District No. 277 Primary Registration District No. 5949 Registrar's No. 29

INDEXED

1. PLACE OF DEATH a. COUNTY <u>PIKE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOWLING GREEN</u> Length of stay in lb <u>-</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>PIKE</u> c. CITY OR TOWN <u>BOWLING GREEN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.F.D 4</u> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL JOSEPH WEBER</u>			4. DATE OF DEATH Month Day Year <u>JULY 24 1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-1913</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SOLE CUTTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE FACTORY</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>NICHOLAS WEBER</u>			13b. MOTHER'S MAIDEN NAME <u>DORA ANDERSON</u>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR II</u>			16. SOCIAL SECURITY NO. <u>490-18-4650</u>		17. INFORMANT <u>N.J. WEBER, BOWLING GREEN MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>coronary sclerosis</u> <u>3 yrs</u> 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 _____ Month, Day, Year _____ a.m. p.m.							
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>9:15 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>M. Matthews M.D.</u>				22b. ADDRESS <u>Bowling Green Mo</u>		22c. DATE SIGNED <u>7-26-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JULY 27, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MISSOURI</u>	
24. FUNERAL DIRECTOR ADDRESS <u>BANKHEAD CHAPEL, BOWLING GREEN, MO</u>			25. DATE RECD. BY LOCAL REG. <u>JULY 27, 1960</u>			26. REGISTRAR'S SIGNATURE <u>Maidie E. Williams</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 10 1960

AUG 10 1960

JUN 5
1961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Harold Kirk

Licensed Embalmer No. 459

P. O. Address Bonking

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.