

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-034114**

**FILED VS OCT 11 1960**

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 304 Registrar's No. 95

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Carrollton</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Carrollton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>403 So. Kinsey</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>403 So. Kinsey</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <b>LILLIE</b> First <b>WEBER</b> Middle Last				<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>3</b> Year <b>1960</b>									
<b>5. SEX</b> <b>Fe.</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10/25/1883</b>		<b>9. AGE (last birthday)</b> <b>76</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during normal working life, even if retired) <b>At home</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Carrollton, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>					
<b>13a. FATHER'S NAME</b> <b>Fred Brockmeier sr.</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Anna Shaeffer</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Louis Weber</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, <b>No</b> ; or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Louis E. Weber,</b> Address <b>Carrollton, Mo.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lupus erythematosus (cause unknown)</b> DUE TO (b) <del>XXXX XXXXXXXXXXXXXXX</del> <b>Arteriolosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH ? ?			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY		STATE					
<b>21. I attended the deceased from</b> <u>Ja. 1/58</u> , to <u>Oct. 3/60</u> and last saw her <u>8:00 p.</u> on <u>Oct. 3/60</u> and to the best of my knowledge, from the causes stated.										her <u>him</u> alive on <u>Oct. 3/60</u>			
<b>22a. SIGNATURE</b> <i>R. Hamilton Staton</i> R. Hamilton Staton, M.D.				<b>22b. ADDRESS</b> Carrollton, Mo				<b>22c. DATE SIGNED</b> Oct 4 1960					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>10/5/1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Hill Cem.</b>		<b>23d. LOCATION</b> (City, town, or county) <b>Carrollton, Mo.</b>							
<b>24. FUNERAL DIRECTOR</b> <b>Gibson Funeral Home, Carrollton, Mo.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>10/5/60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Tom Herbert Carter</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.