

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-047480

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 1613 Primary Registration District No. 33-96 Registrar's No. 77

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 19 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JEFF</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>VALLE</u>		c. CITY OR TOWN <u>DE SOTO</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STAR ROUTE WEST</u>		d. STREET ADDRESS (If outside, give location) <u>Star Route West</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERIC W. WEEKLEY</u>		4. DATE OF DEATH Month Day Year <u>DEC 11 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG 13 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, give if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AMERICAN BEARING PARKERSBURG, W. VIR.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>CLAUDE M. WEEKLEY</u>		13b. MOTHER'S MAIDEN NAME <u>LORENAL CLAYTON</u>	14. NAME OF HUSBAND OR WIFE <u>DIVORCED</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>WALTER WEEKLEY</u>	Address <u>5707 LANDSDOWN ST. - LOUIS, MO</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA -</u> 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 INTERVAL BETWEEN ONSET AND DEATH <u>5- days</u>			
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 <u>COOPER'S VIEW</u> and last saw her/him alive on _____ Death occurred at <u>4:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James R. Palmer M.D. Cooper</u>		22b. ADDRESS <u>Festus Mo.</u>	22c. DATE SIGNED <u>12-11-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/15/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY</u>	23d. LOCATION (City, town, or county) (State) <u>DE SOTO MO</u>
24. FUNERAL DIRECTOR <u>MAHN FUNERAL HOME</u>		ADDRESS <u>DE SOTO MO</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 18-1962</u>
			26. REGISTRAR'S SIGNATURE <u>Marie Farris</u>

**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 *Gualdo J. Maher*

Licensed Embalmer No. 4975

P. O. Address De Soto, 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.