

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

26965

File No. 3572
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson
Township Kaw
City R. & M.

Registration District No. 393
Primary Registration District No. 300
(No. 2737 Cherry)

2. FULL NAME

(a) Residence. No. 2737 Cherry St. St. 3 Ward _____
(Usual place of abode)
(If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles W. Weston

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 22 - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 5 8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER J. W. Orr

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

14. INFORMANT Bary G. Weston

(Address) 5505 College Ave. R. & M.

15. FILED 180, 1930 mm Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 30 1930

17. I HEREBY CERTIFY, That I attended deceased from July 30 to Aug 30 1930
that I last saw him alive on Aug 29, 1930, and that death occurred, on the date stated above, at 7:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Spasmodic Paralysis 80
Several years (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Tobacco (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

18 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) L. J. Hollis M. D.
8/30, 1930 (Address) 708 Ogden St. R. & M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

M. Moriah Sept. 2 1930

20. UNDERTAKER ADDRESS Mrs. C. L. Forster R. & M.

STAMP

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Registration District No. 399 File No.
 Township X City Primary Registration District No. 1002 Registered No. 33-78
 City X City (No.) St. Word)

2. FULL NAME

Mary Olive Weston
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY)

14. INFORMANT
 (Address)

15. FILED 9/30/30 M. M. Crowe REGISTERAR
Am

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 30 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19.....
 that I last saw h. alive on 19....., and that death occurred on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dementia
of many years standing
do not know cause of same
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Tuber. Dorsalis
 (duration) yrs. mos. ds.

18. *WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) L. J. Miller, M. D.
11/21, 1930 (Address) Missouri City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-26765