

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34454

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3552

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kan
(c) Name of hospital or institution: Kansas City Dan Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 ds
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Marie Weed

8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Ray Weed 6. (c) Age of husband or wife if alive Dec 30 1879 years (Month) (Day) (Year)

7. Birth date of deceased Jan 30 1879 (Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 8 If less than one day hr. min.

9. Birthplace Allen town Pa (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name TAM BOWERS

13. Birthplace ALLEN TOWN PA. (City, town, or county) (State or foreign country)

14. Maiden name ELLA CRATER

15. Birthplace ALLEN TOWN PA. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas. J. BOWERS
(b) Address 2733 10 30 St

17. (a) CREMATION (b) Date thereof 9-11-39 (Month) (Day) (Year)
(c) Place: NEWCOMER'S FAIRWEATHER WARNER

18. (a) Signature of funeral director W. WASHINGTON BIVINS
(b) Address 1801 WASHINGTON BLVD. ST. LOUIS
(c) Date received local registrar 9/10/39 (Date received local registrar)

19. (a) 9/10/39 (Date received local registrar) (b) M. M. Crow's (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2932 E. 30th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8 year 1939 hour 4 minute 35 P M.

21. I hereby certify that I attended the deceased from 7-22 1939, to 9-8 1939; that I last saw her alive on 9-8 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Emphysema

Due to Cerebral thrombosis

Due to Cerebral sclerosis arterial

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place) (e) Means of injury

23. Signature P. A. De M... (D. or other) Address Superior... Date signed 9-9-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.