

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

39259  
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 139  
 (b) Township Hill Primary Registration District No. 5200 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

160 John Calvin Weaver  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 13, 1851

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____hrs. or _____min.
	<u>88</u>	<u>7</u>	<u>28</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Jefferson Co. 1  
(STATE OR COUNTRY) Kentucky

FATHER

13. NAME John Weaver 1

14. BIRTHPLACE (CITY OR TOWN) Ash Co. 1  
(STATE OR COUNTRY) North Carolina

MOTHER

15. MAIDEN NAME Delilah Fletcher

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Kentucky

17. INFORMANT Robert A Weaver  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Brassfield Cem. DATE Oct. 13, 1939

19. FUNERAL DIRECTOR (NAME) James D. Gordon  
(ADDRESS) Chillicothe, Mo.

20. FILED 1939 Miss S. E. Perry  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 11, 1939

22. I HEREBY CERTIFY, that I attended deceased from Sept 24, 1939, to Sept 24, 1939  
 I last saw him alive on Sept 27, 1939. Death is said to have occurred on the date stated above, at 9:10 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Fracture of feet  
 Date of onset Aug 39

Other contributory causes of importance:  
Fracture of 2 metatarsals

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Union Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) W. E. ... M. D.  
 (Address) ...

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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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92 H 1

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.....

*Donald F. Gordon*

Registered Apprentice No. *223*

working under my personal supervision.

Signed *James D. Gordon*

Licensed Embalmer No. *1870*

P. O. Address *Lehillicothe*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39269

Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 139  
 (b) Township Hill Primary Registration District No. 2200  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

John Calvin Weaver  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wed

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

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

7. AGE YEARS 88 MONTHS 7 DAYS 28 If LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 1 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death, and related causes of importance were as follows:

Gangrene of feet due to Arterio Sclerosis Date of onset

Other contributory causes of importance:

Senility of myocarditis

Name of operation ..... Date of

What test confirmed diagnosis? A.S.D. Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ..... Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? If so, specify .....

(Signed) Geo. M. Gray, M. D.  
(Address) Lawton mo

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 important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

$$\begin{array}{r} 371 \\ 267 \\ \hline 332 \\ 260 \\ \hline \end{array}$$

$$\begin{array}{r} 697 \\ 1147 \\ \hline \end{array}$$

$$\begin{array}{r} 11357 \\ 1477 \\ \hline \end{array}$$

$$\begin{array}{r} 1485 \\ 21767 \\ \hline \end{array}$$

$$\begin{array}{r} 201925 \\ 22227 \\ \hline \end{array}$$

$$\begin{array}{r} 22227 \\ 22227 \\ \hline \end{array}$$