

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.

FEB 16 1940

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

3517  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Ray Registration District No. 740  
 (b) Township 12 Primary Registration District No. 5976A  
 or Henrietta Mo.  
 (c) City Henrietta Mo. (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 600 Ethel Weir  
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July. 21. 1889

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hra. or .....min.
50	6	9	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife  
 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 \_\_\_\_\_

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carrollton Mo.  
 13. NAME Henry Helsel  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Pa.

MOTHER  
 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carrollton Mo.

17. INFORMANT J. E. Weir  
 (ADDRESS) Henrietta Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn, K. C. Mo. Feb. 1. 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. Thurman Richmond Mo.

20. FILED Jan 31 1940 M. A. Johnson  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 30. 1940 1940

22. I HEREBY CERTIFY That I attended deceased from One call 1940 Jan. 29 1940  
 I last saw him alive on Jan. 29 1940 Death is said to have occurred on the date stated above, at 4:50 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Apoplexy  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: hypertension

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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) [Signature], M. D.  
 (Address) [Address]

RECEIVED  
District Health Officer No. 8,  
District File Number *215/48*  
Date Filed

---

**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.**