

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24304**
Registrar's No. **2914**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson** **3**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
401 East 36th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **45 Days**
(Specify whether
In this community **34 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
0
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2001 E. 69th Terrace**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **Mrs. Florence E. Weaver** **160**
(b) If veteran, name war **No**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** **19** day **19**
year **1940** hour **10** minute **00P.M.**

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Lewis E. Weaver**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **September 10, 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
69 **10** **9** hr. _____ min.

Immediate cause of death **Apoplexy, paralysis of the left side, hypertension.** *Duration*

9. Birthplace **Cooper County Missouri**
(City, town, or county) (State or foreign country)

Due to _____
Due to _____

10. Usual occupation **None**
11. Industry or business **At Home**

Other conditions _____
(Include pregnancy within 3 months of death)

MOTHER FATHER
12. Name **James Hogan**
13. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Mayfield**
15. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____

16. Informant **Mrs. Hubert Spaku**
(b) Address **2001 E. 69 Terrace**

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?

17. (a) **Burial** (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Washington**

While at work? _____ (Specify type of place)
(e) Means of injury _____

18. (a) Signature of funeral director **D. T. ...**
(b) Address **1401 Brush Creek Blvd.**
July 21, 1940
19. (a) (Date received local registrar) (b) **M. M. Crocove**
(Registrar's signature)

23. Signature **James M. Nelson** (M. D. or other) _____
Address **1610 Professional Bldg** signifying _____

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

Dr. James Nelson to
Dr. Fred L. ...
Prof. Bldg.
1-30 Pm.

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. C. 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 this body is not embalmed, above space should be left blank.