

Registration District No. **318**

Primary Registration District No. **5439**

Registrar's No. **592**

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: Springfield Route # 11
(d) Length of stay: In hospital or institution _____
In this community 45 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME CHARLES WESTON

3. (b) If veteran, name war None (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Weston 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased October 6 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days 13 If less than one day hr. min.

9. Birthplace Philadelphia Penna
(City, town, or county) (State or foreign country)

10. Usual occupation Retired
11. Industry or business Furniture & Farm

12. Name Unknown
13. Birthplace No Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Garry Perry Weston
(b) Address Springfield Route 11

17. (a) Burial (b) Date thereof July 20, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood

18. (a) Signature of funeral director Pheme
(b) Address Springfield, Mo.

19. (a) 7-20-41 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

784 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural Springfield
(d) Street No. Springfield Route # 11
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1941 hour 10:50 minute A.M.

21. I hereby certify that I attended the deceased from 2-11, 1941, to 7-18, 1941;
that I last saw him alive on 7-18, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocardial infarction and chronic fibrotic pulmonary disease
Due to Emphysema

Due to 93d
Other conditions Bronchitis

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. H. [unclear] (M.D.)
Address Springfield, Mo. Date signed 7/19/41

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..... *R. H. Quinn*

Licensed Embalmer No. *3681*

P. O. Address. *Springfield, 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, fact should be so stated above.

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