No. 2
1—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 29 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23811

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 151

1. PLACE OF DEATH:
(a) County: Cole
(b) City or town: Jefferson City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Cole 21
(c) City or town: Jefferson City 5
(If outside city or town limits, write "RURAL")
(d) Street No.: 1214 Elmerine Avenue 4
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Joseph Tweedie
3. (b) If veteran, name war
3. (c) Social Security No. none
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: August (Month) 4 (Day) 1883 (Year)

8. AGE: Years 61 Months 11 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace: Jefferson City, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: NONE
11. Industry or business
FATHER 12. Name: John Tweedie
13. Birthplace: Scotland (City, town, or county) 4 (State or foreign country)
MOTHER 14. Maiden name: Anna deBeruff
15. Birthplace: Georgia (City, town, or county) 1 (State or foreign country)
16. (a) Informant: [illegible]
(b) Address: 1021 Adams Street
17. (a) Burial (Burial, cremation, or removal) **(b)** Date thereof: July-7-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn Cemetery
18. (a) Signature of funeral director: [illegible]
(b) Address: Jefferson City, Missouri
19. (a) 7-7-45 (Date received local registrar) **(b)** [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1945 hour 1 minute 30 A. M.
21. I hereby certify that I attended the deceased from July 4, 1945, 19..., to July 6, 1945, 19..., that I last saw him alive on July 6, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Congestion of lungs — Duration 1
Due to: Intestinal Obstruction — Duration 1
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (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)
While at work? (e) Means of injury

23. Signature: W. V. McKully (M. D. or other) M. D.
Address: Jefferson City, Mo. Date signed 7-6-45

494 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 2-19-45

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 Thos. J. Gorcen

Licensed Embalmer No. 1986

P. O. Address Jefferson City 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.

No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 15

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Joseph J Weedie

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 4 (Day) 1885 (Year)

8. AGE: Years 61 Months 4 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July 6
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to July 5, 1945;
that I last saw him alive on July 6, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Gastro-intestinal

Due to obstruction Cause unknown

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation

Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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? — (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)

While at work? — (e) Means of injury

23. Signature Wm. O. McKnelly (M.D. or other) M.D.

Address 405-6 Central Trust Bldg. Jefferson City, Missouri Date signed July 23 1945

JAN 28 1946

23811