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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 14 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41285
Registrar's No. 1025

Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: 625 Franklin
(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

3. (a) PRINT FULL NAME BENJAMIN FRANKLIN WEED

3. (b) If veteran, name war UNK 3. (c) Social Security No. UNK

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife UNK 6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased July 31 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Frisco

MOTHER { 12. Name Unknown

13. Birthplace Unknown UNK
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown UNK
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J.B. McMannis

(b) Address San Diego, California

17. (a) Burial (b) Date thereof 12/18/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 12-15-45 (b) B. W. E. Haudy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 625 Franklin 6
(If rural, give location) 8

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 12 year 1945 hour 9: minute 50 P.A.M.

21. I hereby certify that I attended the deceased from Dec 4 1945 to Dec 12 1945 that I last saw him alive on Dec 12 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Attack Duration 20 min

Due to Influenza

Due to _____

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

Major findings: Of operations no Of autopsy no

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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? no (e) Means of injury no

23. Signature U. F. Kern (M. D. or other) U
Address Springfield Mo Date signed Dec 17 1945

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..... *L. A. Roof*

Licensed Embalmer No..... *3044*

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.