

No. 2  
1-5-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15903

State File No. \_\_\_\_\_  
Registrar's No. 156

FILED MAY 20 1946

Registration District No. 3 Primary Registration District No. 5135

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

1. PLACE OF DEATH:

(a) County Butler

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

(c) Name of hospital or institution: Home Asst Hill  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Connie Sharon Weeks

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 4 1946  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 9 hr. min \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Hadley Weeks

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

14. Maiden name Cornelia Riggs

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

16. (a) Informant Hadley Weeks

(b) Address Quilin, Mo. R.R.

17. (a) Burial (b) Date thereof 5-7-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Campbell

18. (a) Signature of funeral director Friends of Quilin

(b) Address Quilin Mo

19. (a) 5/11/46 (b) R. H. Muntz  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12

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

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

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5  
year 1946 hour \_\_\_\_\_ minute 4:30 AM.

21. I hereby certify that I attended the deceased from May 4 - 1946  
\_\_\_\_\_ 19\_\_\_\_ to May 5 - 1946  
\_\_\_\_\_ 19\_\_\_\_

that I last saw her alive on May 4  
and that death occurred on the date and hour stated above.

Immediate cause of death: Paralysis of Diaphragm Duration 2 hr

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN 872

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 \_\_\_\_\_

Signature Scott Cook (M. D. or other) \_\_\_\_\_

Address Quilin Mo Date signed \_\_\_\_\_

RECEIVED

District Health Office No. 2

District File Number 546-623

Date Filed 5-16-46

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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, fact should be so stated above.