

Registration District No. 1375

Primary Registration District No. 6118

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Death  
 (b) City or town Oran R.F.D.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: None  
 (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 Mo (b) County Scott  
 (c) City or town ORAN Mo  
 (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 FLORA JEANNE WEAKLEY

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

4. Sex FEM. ♀ 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced   
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov 14 1944  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 8 14 hr. \_\_\_\_\_ min.

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

10. Usual occupation child

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

12. Name NONE (USING MOTHER'S NAME)  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 14. Maiden name HARVEY LEE WEEKLEY  
 15. Birthplace Miss. (City, town, or county) (State or foreign country)

16. (a) Informant MOTHER

(b) Address ORAN MO  
 17. (a) BURIAL (b) Date thereof 7/29/46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McMULLIN  
 18. (a) Signature of funeral director Neisserer Fun Home  
 (b) Address Oran Mo

19. (a) 8/30/46 (b) Spickman  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 28th  
 year 1946 hour 1 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 that I last saw him \_\_\_\_\_ alive on July 28, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Suffocation  
 Due to Heat & Sleeping position  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 182  
 40

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature Orville Taylor (M. D. or other) Crown  
 Address Sebastian Mo Date signed 7-31-46

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REGISTER HERE

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

823

RECEIVED

District Health Office No.

District File Number 846-100

Date Filed 8-31-46

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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.**

Registration District No. 335

Primary Registration District No. 6118

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Floia J. Weakley  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased mo. 14  
(Month) (Day) (Year)

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

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

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

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ (hour) \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death: Asphyxiation

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

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 162  
110

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) Accident

(b) Date of occurrence 7-28-46

(c) Where did injury occur? Scott, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Public Cemetery (Specify type of place)

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

23. Signature Orville Taylor (M. D. or other) Coroner  
Address Sikeston, Mo. Date signed \_\_\_\_\_

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

28134

SUPPLEMENTARY

29296