

THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30044
Registrar's No. 773

FILED OC 12 1946

Registration District No. _____ Primary Registration District No. 2000

1. PLACE OF DEATH: **GREENE**
(a) County _____
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
In this community 60 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Nichols Junction
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARY L. WESTON
3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 25th
year 1946 hour 8:35 P.M. minute _____ M. _____
21. I hereby certify that I attended the deceased from Aug 20
1946 to Sept. 25, 1946.
that I last saw her alive on Sept. 25, 1946.
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife Charles Weston 6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased September 17 1863
(Month) (Day) (Year)

Immediate cause of death Arterial Sclerotic Heart Disease Duration 2 days
Due to _____
Due to _____
Other conditions Fracture, right hip bones
(Include pregnancy within 3 months of death).

8. AGE: Years 83 Months 0 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business None

12. Name Samuel Kettle

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

14. Maiden name Unknown

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

16. (a) Informant Hal Hamilton
(b) Address Springfield, Missouri

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1946
(Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Fred C. Thieme
(b) Address Springfield, Mo.

19. (a) 9-26-46 (Date received local registrar) (b) W. J. Handley M.D. (Registrar's signature)

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 39
(b) Date of occurrence Aug. 16, 1946
(c) Where did injury occur? Nichols Junction, Greene, Mo.
(City, town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature W. J. Handley (M. D. certifier)
Address Springfield, Mo. Date signed 9/26/46

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

71
6

111

2

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.....

Ralph H. Thieme

Licensed Embalmer No. 3661

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.

Registration District No. 120

Primary Registration District No. 2000

Registrar's No. 773

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:
(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 Mary J. Weston

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

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

8. AGE: Years 83 Months _____ Days _____ (less than one day) hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (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 _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug. 25, 1946 to Sept. 25, 1946, that I last saw him Sept. 25, 1946 alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions fracture, intertrochanteric 5 w/o
(Include pregnancy within 3 months of death)

Major findings right femur Aug 19, 1946

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 Aug. 19, 1946

(c) Where did injury occur? Nielsen Junction, Greene, Mo
(City or town) (County) (State)

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

While at work? no (Specify type of place) (e) Means of injury Fell down

23. Signature James D. Johnston (M. D. or other) _____

Address Springfield, Mo. Date signed 10/11/46

SUPPLEMENTARY

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

28879

3880

30044