

dec 181

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 70 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. Route 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNA PAULINE WEAVER

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 1 - 5 - 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 26
If less than one day hr. _____ min. _____

9. Birthplace Spotsylvania County Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name Richard F. Johnson
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Jerrel
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Edgar Weaver
(b) Address Route 1, Columbia, Mo.

17. (a) Burial (b) Date thereof 1-3-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Olivet Cemetery

18. (a) Signature of funeral director Parson Funeral Service
(b) Address Columbia, Mo.

19. (a) Jan 3 1947 (b) Mrs R E Palmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 1
year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from for 40 yrs.
_____ 19____ to _____ 19____
that I last saw her alive on Dec. 28 - 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hem. Duration HTC.

Due to Deficient for 6 or 8 yrs.

Due to _____

Other conditions Severe Deformities Hips
(Include pregnancy within 3 months of death)

Major findings: None PHYSICIAN _____
Of operations _____
Of autopsy None
-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) No
(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? No

While at work? No (Specify type of place) (c) Means of injury 0

23. Signature W. P. Nesbitt (M. D. or other) _____
Address Columbia, Mo. Date signed 1-3-47

31

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

DATE FILED JAN 14 1947

District File Number

District Health Officer No. 9

RECEIVED

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 *M. D. Whitfield*

Licensed Embalmer No. *3893*

P. O. Address *Columbia 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.