

No. 2  
-12-45  
-5-17-39  
I X47070

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12499  
Registrar's No. 340

FILED APR 23 1947  
Registration District No. 228

Primary Registration District No. 2000

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:  
1530 Washington Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Years (Specify whether years, months or days)

In this community 2 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 1530 Washington Ave.  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME AARON JAMES WEAVER

3. (b) If veteran, name war none

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

4. Sex male 5. Color or race White

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

6. (b) Name of husband or wife Elnora Weaver

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

7. Birth date of deceased December 13, 1869  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77	3	28	hr. min.
----	---	----	----------

9. Birthplace Columbia, Tennessee  
(City, town, or county) (State or foreign country)

10. Usual occupation Cashier

11. Industry or business L.B. Price Mercantile Co.

12. Name James T. Weaver

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

14. Maiden name Louise Wilks

15. Birthplace Mt. Pleasant, Tennessee  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma L. Jackson

(b) Address 1530 Washington Ave., Springfield, Mo.

17. (a) Removal (b) Date thereof April 13, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dallas, Texas

18. (a) Signature of funeral director Fred C. Thieme

(b) Address Springfield, Mo.

19. (a) 4-13-47 (b) W. H. Landry, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11th  
year 1947 hour 6:15 P.M. minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from 15 February 1947 to 11 April 1947  
that I last saw him alive on 3 April 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Cerebral hemorrhage

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

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

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

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

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 Samuel E. Knott, M.D. (M. D. or other) \_\_\_\_\_

Address 450 1/2 E. Commercial Date signed 12 April 47

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

MOYLER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAY 28 1947

AUG 4 1948

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. Thicome

Licensed Embalmer No. 3681

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.

7-2-48