FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 1 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25338

Registration District No. 1 Primary Registration District No. 5000 Registrar's No. 259

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: A.C. Laughlin Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 12 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Van Buren

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

(d) Street No. RFD
(If rural, give location)

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

If yes, name country none

3. (a) PRINT FULL NAME Oscar Weatherington

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race W

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

6. (b) Name of husband or wife Lydia Kline

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

7. Birth date of deceased Aug (Month) 23 (Day) 1876 (Year)

8. AGE: Years 72 Months 0 Days 9 If less than one day hr. min.

9. Birthplace Milton (Rural) Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Weatherington
13. Birthplace Milton Iowa
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Jane McQuaid
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Oscar Weatherington
(b) Address Milton Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (Month) (Day) (Year)
(c) Place: burial or cremation Lebanon Cem
Milton Iowa (Rural)

18. (a) Signature of funeral director H.A. Burnett
(b) Address Keosauqua Ia

19. (a) 9-9-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1948 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from 3/28 1948 to 9/2 1948
that I last saw him alive on 9/1 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute dilatation of the heart	5 min
Due to Cardiac & bronchial asthma with	yrs.
Due to associated cardiac decompensation	mos.
Other conditions Hypertensive Heart Disease (Include pregnancy within 3 months of death)	yrs.

Major findings:
Of operations 93
Of autopsy

PHYSICIAN
Underline the cause of 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

23. Signature H. D. McClure (M. D. or other) DO
Address Kirksville, Mo Date signed 9/2/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 9-48-1
Date Filed SEP 13 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 H. A. Burnett

Licensed Embalmer No. 2668

P. O. Address Keosauqua

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.