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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 27 1948

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 28977

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1000

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4yr 3mo 29day (Specify whether
In this community 4yr 3mo 29 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 25
(a) State Mo (b) County Clinton
(c) City or town Gower Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Sarah Weakley
3. (b) If veteran, name war XX
3. (c) Social Security No. XX
4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Orph. C Weakley
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. (Month) 3 (Day) 1873 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 7 | 18 | hr. min. |

9. Birthplace Clinton Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housework
11. Industry or business
FATHER
12. Name not given 7
13. Birthplace (City, town, or county) (State or foreign country) 1
MOTHER
14. Maiden name not given 0
15. Birthplace (City, town, or county) (State or foreign country) 1
16. (a) Informant Bryan Weakley
(b) Address Gower Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 23 48 (Month) (Day) (Year)
(c) Place: burial or cremation Gower Mo.
18. (a) Signature of funeral director D. D. Lyon
(b) Address Plattsburg, Mo.
19. (a) 9-22-48 (Date received local registrar) (b) G. A. Jenkins (Registrar's signature) 582

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21
year 1948 hour 4 minute 15 P M.
21. I hereby certify that I attended the deceased from Sept 1
~~Sept~~ 1948, to Sept 21, 1948
that I last saw her alive on Sept 21, 1948
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Bronch. Pneumonia | |
| Due to Senility | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

107

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) 0
While at work? (e) Means of injury

23. Signature Tomas Thomas (M. D. ~~XXX~~er)
Address St. Joseph Mo Date signed 9/21-48
of State Hospital No 2

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

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 Darell D. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburg, NY

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.