

No. 300
10-48

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4694

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BIRTH NO. _____ REG. DIST. NO. 382 PRIMARY REG. DIST. NO. 4228 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY HOWARD		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE MISSOURI b. COUNTY HOWARD	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN GLASGOW	c. LENGTH OF STAY (in this place) 12 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN GLASGOW	
d. FULL NAME OF HOSPITAL OR INSTITUTION GLASGOW MO		d. STREET ADDRESS (If rural, give location) CITY	

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) KATHERINE c. (Last) WEBER			4. DATE OF DEATH JAN 23 1950 (Month) (Day) (Year)			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEB. 15, 1877	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Month Days	IF UNDER 1 HRS. Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HER HOME	11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME WILLIAM MERHOFF	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE HENRY WEBER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Mrs Agnes Vosler ADDRESS Glasgow

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 30 hrs.	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Basilar pneumonia			3 days
	DUE TO (c) Diabetes mellitus			10 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-21, 1950, to 1-23, 1950, that I last saw the deceased alive on 1-23, 1950, and that death occurred at 2:30 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. P. Gardner MD	23b. ADDRESS Glasgow Mo.	23c. DATE SIGNED 1-24-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 25 1950	24c. NAME OF CEMETERY OR CREMATORY Washington	24d. LOCATION (City, town, or county) (State) Glasgow Mo.
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DATE REC'D BY LOCAL REG Jan 24 - 1950	REGISTRAR'S SIGNATURE Walker Audley	25. FUNERAL DIRECTOR'S SIGNATURE Audley-Friemuth ADDRESS Glasgow Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED FEB 8
District Health Officer No. 8,
District File Number _____
Date Filed 2-23-50

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed J. Walker Cudeley
Licensed Embalmer No. 3336

P. O. Address Glasgow 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.