

Health
Welfare
Public
Service

300
-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38893

FILED NOV 26 1956

STATE FILE NUMBER

Registration District No. 243 Primary Registration District No. 5831 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>Newton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Franklin Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Stark City, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>			Length of stay in lb <u>Life</u>		d. STREET ADDRESS (If outside, give location) <u>Stark City, Mo. R#</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>George</u> Last <u>Weems</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 30 1885</u>		9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (City and state or country) <u>Newton Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Silas V. Weems</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Charlton</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>489-24-6730</u>		17. INFORMANT <u>Lottie Weems</u>			Address <u>Stark City, Mo. R#</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anginal pectus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4202</u>								INTERVAL BETWEEN ONSET AND DEATH <u>(2)</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>4-7-56</u> to <u>10-17-56</u> and last saw ^{her} _{him} alive on <u>10-17-56</u> Death occurred at <u>9:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>C. Cardwell M.D.</u>				22b. ADDRESS <u>Stella Mo.</u>				22c. DATE SIGNED <u>11-13-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 20 56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Weems Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Stark City, Mo. R#</u>			
24. FUNERAL DIRECTOR <u>W. Morris Pope</u>				ADDRESS <u>Wheaton, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-13-1956</u>		25. REGISTRAR'S SIGNATURE <u>Alpha Dyer</u>	

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. Newton
District File Number 1156-191
Date Filed **NOV 20 1956**

NOV 20 1956

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..

Student.....
Signature of Student Embalmer

Signed W. Morris Payne

Licensed Embalmer No. 24

P. O. Address Wheaton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.