

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24892

STATE FILE NUMBER

3370

FILED AUG 12 1957 Registration District No. 199 Primary Registration District No. 1002 Registrar's No.

Health, Welfare Public Service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
Doctor, coroner, etc., may use only standard nomenclature in Part I. No symptoms will be listed.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Polk	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN HUMANSVILLE	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		d. STREET ADDRESS	
Length of stay in lb 50 days		(If outside, give location) 0840	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JOHN Middle YOUNG Last WEIR			4. DATE OF DEATH Month July Day 17 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1886	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Humansville, Missouri	
13. FATHER'S NAME William F. Weir		14. MOTHER'S MAIDEN NAME Dorothy S. Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. NONE		17. INFORMANT VA Hospital Official Records, K. C. Mo.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 89:30
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Multiple decubitis and malnutrition DUE TO (c) Old fracture of hip, January 1957 with draining sin.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old fracture of rt hip, January 1957 with draining sinuses		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input checked="" 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.) 084	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. Jan 1957	Fall on some ice near Humansville, Missouri	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION COUNTY STATE Humansville, Polk, Mo.

21. I attended the deceased from May 28, 1957 to July 17, 1957 when he died Death occurred at 8:45 AM m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE George A Higgins, M.D. (Degree of title)	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 7-17-57

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 7-18-57	23c. NAME OF CEMETERY OR CREMATORY —	23d. LOCATION (City, town, or county) (State) Humansville, Mo.
24. FUNERAL DIRECTOR Beckwith Mortuary, Humansville, Mo.	25. DATE RECD. BY LOCAL REG. 7-18-57	26. REGISTRAR'S SIGNATURE Vera Minshall	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John R. Sidm*
Licensed Embalmer No. 43
P. O. Address *Kansas*

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.

(K)