

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39358
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1211

V. S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hosp.		Length of stay in lb 25 years	d. STREET ADDRESS (If outside, give location) Pioneer Hotel Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Wee Last Weeger			4. DATE OF DEATH Month Nov. Day 3 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 29, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired cook		10b. KIND OF BUSINESS OR INDUSTRY Restauran	9. AGE (In years last birthday) 74
11. BIRTHPLACE (City and state or country) Schaller, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jacob Weeger		13b. MOTHER'S MAIDEN NAME Nancy Cchwell	14. NAME OF HUSBAND OR WIFE Ruth Weeger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 506-20-9302	17. INFORMANT Address Mrs. Margaret Tucker, Wathena, Kansas
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myo-cardial Infarction DUE TO (b) Cardio Renal Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			INTERVAL BETWEEN ONSET AND DEATH 1 week Unk.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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.			
20d. INJURY OCCURRED WHILE AT <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 5/24/57 to 11/3/57 and last saw her ^{him} alive on 11/2/57 Death occurred at 2:20a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Robert Fulton</i>		22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED 11/4/57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11/3/1957	23c. NAME OF CEMETERY OR CREMATORY Foster Cemetery	23d. LOCATION (City, town, or country) (State) New Hampton, Mo.
24. FUNERAL DIRECTOR Heaton-Bowman		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Nov. 12, 1957
		26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>	

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 causally related.

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 *James B. Hawkins*

Licensed Embalmer No. *4536*

P. O. Address *319 E. 10th St. Des Moines*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.