ept. Health,
c., & Welfare
J. S. Public
alth Service

V. S. 300
Rev. 1-57

FILED JAN 20 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 47192

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 225

1. PLACE OF DEATH
a. COUNTY Grundy
b. CITY OR TOWN Trenton — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Cullen Hospital — Length of stay in Hospital 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Grundy
c. CITY OR TOWN Galt — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) Rural — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First URSA Middle CLEVELAND Last WESTON

4. DATE OF DEATH Month 12 Day 24 Year 57

5. SEX M
6. COLOR OR RACE W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Oct 12 1885
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Physician
10b. KIND OF BUSINESS OR INDUSTRY M.D.
11. BIRTHPLACE (City and state or country) Grundy Co Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME W B Weston
13b. MOTHER'S MAIDEN NAME Alta Johnson
14. NAME OF HUSBAND OR WIFE Bertie Todd Weston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. 496-42-3748
17. INFORMANT Mrs Bernadette Wiggins Address Trenton Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH About 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 Dec. 24-1957, to Dec 24-1957 and last saw her/him alive on Dec. 24-1957
Death occurred at 5:30 Pm. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE O H Cullers (Degree or title) M.D.
22b. ADDRESS Trenton, Mo.
22c. DATE SIGNED 12-26-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-27-57
23c. NAME OF CEMETERY OR CREMATORY Camp Ground Cem.
23d. LOCATION (City, town, or county) (State) Osgood Mo

24. FUNERAL DIRECTOR P K Payne Son
ADDRESS Galt Mo
25. DATE RECD. BY LOCAL REG. 12-27-57
26. REGISTRAR'S SIGNATURE Irene Fair

(Licensed Embalmer's Statement on Reverse Side)

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.

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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 P K Payne Jr.

Licensed Embalmer No. 3400

P. O. Address Galt

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.