

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010973  
STATE FILE NUMBER

FILED MAR 24 1958

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 161

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cathwell Hospital</u>		Length of stay <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>1014 East 10<sup>th</sup></u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>Sophia</u> Last <u>Weise</u>			4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8 1979</u>	9. AGE (In years last birthday) <u>78</u>	10. FUNDING YEAR Months <u>9</u> Days <u>8</u>	11. IF UNDER 24 HRS. Hours <u>5</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Sedalia Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>Robt. Laystrom</u>	13b. MOTHER'S MAIDEN NAME <u>Minnie W. Sarman</u>	14. NAME OF HUSBAND OR WIFE <u>William Weise</u>
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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>578-28-6869</u>	17. INFORMANT <u>Carl A. Weise</u> Address <u>Raytown Mo</u>
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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>Terminal Pneumonia.</u> <u>Uremia.</u> <u>Cerebral Hemorrhage-Rt. Hemiplegia.</u> DUE TO (b) <u>3-9-58/</u> DUE TO (c) <u>Arterio- Sclerosis. Advanced.</u> ?		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours duration.</u> <u>72 hours duration.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None other.</u>		19. WAS AUTOPSY PERFORMED? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>None.</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>/</u>
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20c. TIME OF INJURY Hour <u>None.</u> Month, Day, Year a.m. <u>None.</u> p.m.
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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.) <u>None.</u>	20f. CITY, TOWN, OR LOCATION <u>None.</u>	COUNTY <u>None.</u>	STATE <u>None.</u>
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21. I attended the deceased from over 25 years to March 16th and last saw her alive on March 16th, 1958.  
Death occurred at 4.25 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jno. B. Carlisle, M.D.</u>	22b. ADDRESS <u>105 Sedalia, Missouri.</u>	22c. DATE SIGNED <u>3-17-58.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-18-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	23d. LOCATION (City, town, or county) <u>Sedalia</u>	(State) <u>Mo</u>
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24. FUNERAL DIRECTOR <u>McLaughlin Bros Sedalia</u>	ADDRESS <u>Sedalia</u>	25. DATE RECD. BY LOCAL REG. <u>3-17-1958</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

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Doctor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms with this disease. All diseases in Part I must be causally related.

APR 3 1958

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 *K.P.M. Leary* .....

Licensed Embalmer No. *3753* .....  
P. O. Address *Sedalia* .....

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.