

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017421
STATE FILE NUMBER

FILED MAY 26 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 520

5. 300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 0117 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp		Length of stay in lb 2yrs.	d. STREET ADDRESS 111 E. Moose St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Gail Louise Weston			4. DATE OF DEATH Month Day Year May 13 1958
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20-1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 2 IF UNDER 1 YEAR Months Days Hours Min. 0
11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Leon T. Weston		13b. MOTHER'S MAIDEN NAME Dorothy Pullins	14. NAME OF HUSBAND OR WIFE None
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. None	17. INFORMANT Address Leon T. Weston-111 E. Moose St. City
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>Bella donna poisoning</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>due to overdose of Hinkle pills</u> DUE TO (c) <u>8779</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>46</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
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 131 1117	COUNTY STATE
21. I attended the deceased from <u>May 12 - 5P</u> to <u>May 13 - 5P</u> and last saw her alive on <u>May 13 - 5P</u> Death occurred at <u>5:00</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. J. Sheard</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Doctors Bldg</u>	22c. DATE SIGNED <u>5-16-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE May 17-1958	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR <u>Wm. H. Alexander</u> ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. <u>May 19, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>

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 *Wm. H. Alexander*

Licensed Embalmer No. *4450*
P. O. Address *St. Joseph*

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.