

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046863  
STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 324 Primary Registration District No. 3022 Registrar's No. 221

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Marshall</b> <b>09720</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ritzgibbon hospital</b>		Length of stay in lb <b>5 years</b>	d. STREET ADDRESS (If outside, give location) <b>611 N. Hamner</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Artie</b> Middle <b>Edwin</b> Last <b>Weeks</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>31st</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1906</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. of schools</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Public schools</b>	11. BIRTHPLACE (City and state or country) <b>Linn, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Robert Franklin Weeks</b>	13b. MOTHER'S MAIDEN NAME <b>Bertha Carey</b>	14. NAME OF HUSBAND OR WIFE <b>Helen Dorothy Weeks</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>493-26-2601</b>	17. INFORMANT <b>Mrs Helen Dorothy Weeks, Marshall, Mo.</b> Address
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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) <b>Renal Failure, Chremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks X</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Myocardial infarction</b>		<b>1 yr X</b>
	DUE TO (c) <b>Hypertension</b>		<b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>445X</b>		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.)
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20c. TIME OF INJURY Hour <b>7-30 A.M.</b> Month, Day, Year
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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 <b>Marshall, Mo</b>	COUNTY <b>Saline</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **1954** to **Dec 30, 1956** and last saw her alive on **Dec 30, 1958**  
Death occurred at **7-30 A.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Yawn E. Roehrs M.D.</b> (Deputy or title)	22b. ADDRESS <b>Marshall, Mo</b>	22c. DATE SIGNED <b>12/31/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 3, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Linn Cemetery</b>	23d. LOCATION (City, town, or county) <b>Linn, Missouri</b> (State)
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24. FUNERAL DIRECTOR <b>Campbell-Lewis, Marshall, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-31-1958</b>	26. REGISTRAR'S SIGNATURE <b>Cecil H. Read</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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MAR 11 1959  
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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 James A. Lewis .....  
Licensed Embalmer No. 4709 .....  
P. O. Address Marshall .....

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.