

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004639  
STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 163

300  
-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
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 12021/2 Grand Ave.		Length of stay in lb 20 yrs	d. STREET ADDRESS (If outside, give location) 1202-1/2 Grand Ave.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE Last FLOYD JAMES WEIR			4. DATE OF DEATH Month Day Year Feb 10 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1914	9. AGE (In years last birthday) 44	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Goetz Brewery	11. BIRTHPLACE (City and state or country) Savannah Missouri	12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME James Weir		13b. MOTHER'S MAIDEN NAME Esther Brown		14. NAME OF HUSBAND OR WIFE Mrs. Lavina Weir	
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. 487-14-7197		17. INFORMANT Mrs. Lavina Weir Address 2104-1/2 So. Belt St. Joseph, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Gastrointestinal Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH Weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Probable Bleeding Ulcer		Weeks
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5400			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 Month, Day, Year 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 <u>unattended</u> to <u>Found</u> and last saw <u>xxx</u> him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John S. Clark MD</u> (Degree or title) City Health Officer				22b. ADDRESS 5302 Faran	
				22c. DATE SIGNED 2-11-59	

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-13-59		23c. NAME OF CEMETERY OR CREMATORY Savannah Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Missouri	
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24. FUNERAL DIRECTOR <u>Stamey Funeral Home</u> ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 12, 1959		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Standell</u>	
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All diseases in Part I must be causally related.

Dr. I. H. Pifer  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FEB 20 1956

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 *Charles E. Bennett* .....

Licensed Embalmer No. *4677* .....

P. O. Address *St. Joseph Mo* .....

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.