

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012174  
STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 1 Primary Registration District No. Registrar's No. 129

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Yarrow</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Yarrow</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		Length of stay in lb <b>yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>0010</b>
3. NAME OF DECEASED (Type or print) First <b>HARRISON</b> Middle <b>WEBER</b> Last <b>WEBER</b>			4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1959</b>
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>April 25, 1882</b>
9. AGE (In years (birthday)) <b>76</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>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Macon County, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Michael Weber</b>		13b. MOTHER'S MAIDEN NAME <b>Magnolia Hays</b>	
14. NAME OF HUSBAND OR WIFE <b>Lettie (Biggs) Weber</b>			
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>489-42-0207</b>	
17. INFORMANT Address <b>Lettie Weber, Yarrow, Missouri</b>			
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>Cerebral hemorrhage</b> DUE TO (b) <b>arteriosclerosis-generalized.</b> DUE TO (c) <b>331X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Myocarditis - cardiac insufficiency</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b> <b>3 years</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.)	
20c. TIME OF INJURY Hour <b>9:30 A</b> Month, Day, Year <b>March 1944</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>April 18, 1959</b>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>Kirksville, Mo.</b>	
21. I attended the deceased from Death occurred at <b>9:30 A</b>		21. I attended the deceased from <b>March 1944</b> to <b>April 18, 1959</b> and last saw him <b>alive on Apr. 17, 1959</b>	
22. SIGNATURE <b>Spencer L. Freeman M.D.</b> (Degree or title)		22b. ADDRESS <b>Kirksville, Mo.</b>	
22c. DATE SIGNED <b>Apr. 21, 1959</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-20-1959</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Yarrow Cemetery</b>		23d. LOCATION (City, town, or county) <b>Yarrow, Missouri</b>	
24. FUNERAL DIRECTOR <b>Davis &amp; Davis, Kirksville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-24-1959</b>	
26. REGISTRAR'S SIGNATURE <b>Doris W. Raloff</b>			

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

0 300 1-57

SPENCER L. FREEMAN M.D.  
 All diseases in Part I must be causally related.  
 Doctor, coroner, etc. must use only standard nomenclature in item 16. No symptoms with no history.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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 *Robert B. Davis* .....

Licensed Embalmer No. 4219 .....  
P. O. Address Kirkville, 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.