

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014256
STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 201 Primary Registration District No. 3048 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY <u>NODAWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>NODAWAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARYVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CONCEPTION Jct.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS</u>		Length of stay in 1b <u>2 dy</u>	d. STREET ADDRESS (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 <u>LLOYD FRANCIS WEATHERMON</u>			4. DATE OF DEATH Month Day Year <u>APRIL 23 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3 WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1904</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WABASH R.R.</u>	11. BIRTHPLACE (City and state or country) <u>GUILFORD, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>HOWARD F. WEATHERMON</u>		13b. MOTHER'S MAIDEN NAME <u>JDA Mc MACKIN</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>	
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>702-05-6780</u>		17. INFORMANT <u>SUBMYRTLE</u> Address <u>KANSAS CITY, MO</u> <u>Mrs. MARY FRANCES KERNS</u>	

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>Cardiac decompensation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic myocarditis</u>		?
	DUE TO (c) <u>Coronary atherosclerosis 4201</u>		?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic bronchitis & emphysema</u>			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 10-1-57 to 4/23/59 and last saw him alive on 4/23/59
Death occurred at 12 30 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B. J. Gland M.D.</u>	22b. ADDRESS <u>Maryville, Missouri</u>	22c. DATE SIGNED <u>4/30/59</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WEATHERMON</u>	23d. LOCATION (City, town, or county) <u>GUILFORD, MO.</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>JOHNSON FUNERAL HOME,</u>	ADDRESS <u>CONCEPTION Jct., MO.</u>	25. DATE RECD. BY LOCAL REG. <u>5-1-59</u>	26. REGISTRAR'S SIGNATURE <u>Bess Holt</u>
--	--	---	---

(Licensed Embalmer's Statement on Reverse Side)

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

MAY 13 1959

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 *Leslie E. Johnson*

Licensed Embalmer No. *4948*

P. O. Address *Stamberg*

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.