

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024712

FILED VS AUG 4 1959 0

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 71

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Gentry</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Albany</u> Length of stay in 1b <u>lifetime</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gentry County Memorial Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u> c. CITY OR TOWN <u>Albany,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Robert</u> Last <u>Weller</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>26</u> Year <u>1959</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5/26/72</u>	<b>9. AGE</b> (last birthday) <u>87</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired farmer</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Breckenridge, Ky.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>		<b>13a. FATHER'S NAME</b> <u>Sylvester Weller</u> <b>13b. MOTHER'S MAIDEN NAME</b> <u>Willie Board</u> <b>14. NAME OF HUSBAND OR WIFE</b> <u>Magnolia S. Weller</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>O.W. Weller</u> Address <u>Bethany, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO (b) <u>Aortic Aneurism</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year <u>7-1-59</u> a.m. _____ p.m. _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> <u>Albany, Gentry Mo.</u> COUNTY STATE				
<b>21. I attended the deceased from</b> <u>7-1-59</u> to <u>7-26-59</u> and last saw him alive on <u>7-26-59</u> Death occurred at <u>8:15 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Frank H. Rose, M.D.</u>			<b>22b. ADDRESS</b> <u>Albany Mo.</u>				
<b>22c. DATE SIGNED</b> <u>7-27-59</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>		<b>23b. DATE</b> <u>July 29, 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairview</u>				
<b>23d. LOCATION</b> (City, town, or county) (State) <u>Gentry Co. Missouri</u>							
<b>24. FUNERAL DIRECTOR</b> <u>Clifford Brooks, Albany, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-29-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. L. W. Base</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by me \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donald E. Cochely

Licensed Embalmer No. 4868

P. O. Address Albany, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.