

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031349

FILED VS. OCT 5 1959

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 293

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Wheeler</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wheeler</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Antiochville Mo.</u> Length of stay in 1b		c. CITY OR TOWN <u>Queen City</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>N. St. Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET LENORA WEIR</u>			4. DATE OF DEATH Month Day Year <u>Sept 25 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1872</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not working</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Missouri Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles H. Weir</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Henry</u>	
14. NAME OF HUSBAND OR WIFE <u>William Weir</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.	
17. INFORMANT <u>Sida Van Sickle</u>		Address <u>Queen City Mo.</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>Coronary artery disease</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ 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) <u>Fracture right hip</u>		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		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) <u>Fell at home</u>			
20c. TIME OF INJURY Hour Month, Day, Year <u>9-11-59</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Queen City</u>	
20f. CITY, TOWN, OR LOCATION <u>Queen City</u>		COUNTY <u>Wheeler Mo.</u>		STATE	
21. I attended the deceased from <u>9-11-59</u> to <u>9-25-59</u> and last saw her alive on <u>9-20-59</u> Death occurred at <u>5-25 PM</u> on the date stated above, and to the best of my knowledge, from the cause stated.					
22a. SIGNATURE <u>Addison A. Frank</u>		(Degree or title)		22b. ADDRESS <u>Frankville Mo.</u>	
22c. DATE SIGNED <u>9-16-59</u>		23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-21-59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wheeler Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wheeler Mo.</u>		23e. STATE	
24. FUNERAL DIRECTOR <u>Wheeler</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Sept. 26, 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Dora W. Ratliff</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Addison Howes, D. O.

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.

OCT 6 1950