

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032064

FILED VS OCT 5 1959 28

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 1009

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD MO		c. CITY OR TOWN STRAFFORD MO RI	
Length of stay in 1b 15 DAYS		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE Hosp		d. STREET ADDRESS (If outside, give location) 5 Mi N.E.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HARRISON WEACH			4. DATE OF DEATH Month Day Year SEPT 24 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 10-1-1893	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET STATE EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME WILLIAM W. WEACH		13b. MOTHER'S MAIDEN NAME AMERICA SHELBY		14. NAME OF HUSBAND OR WIFE EVA			
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. 567-12-9164		17. INFORMANT EVA WEACH STRAFFORD RI			
Address							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 5 DA.
IMMEDIATE CAUSE (a) UREMIA			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA OF PROSTATE AND. DUE TO (c) POST OPERATIVE OLIGURIA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 13 DAY POST OP. CHOLECYSTECTOMY: HYPERTENSION			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

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 a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <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 SEPT. '59 to 24 SEPT. '59 and last saw him alive on 23 SEPT. '59		
Death occurred at 4:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <i>W. W. Rober M.D.</i> (Degree or title)	22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 25 Sept. '59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9-24-1959	23c. NAME OF CEMETERY OR CREMATORY MT OLIVE	23d. LOCATION (City, town, or county) (State) WEBSTER CO MO
24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD		25. DATE RECD. BY LOCAL REG. 9-28-59	26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1959 OCT 14

VS OCT 14 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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *R. W. Book*

Licensed Embalmer No. 38
P. O. Address *W. H. Grove*

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.