

**FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE**

**U.S. PUBLIC HEALTH SERVICE
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE**

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 9 6 6

FILED VS JAN - 4 1960 / 28

Registration District No. _____ Primary Registration District No. 2020 Registrar's No. 1357C STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>22 years</u>		c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1927 E. Monroe Ter.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>Hans</u> Middle <u>-----</u> Last <u>Weatherman</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1959</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/5/1878</u>		9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Railroad Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N. Western R.R.</u>		11. BIRTHPLACE (City and state or country) <u>-----S. Dakota</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>											
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Effie Weatherman</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>491-05-3912</u>		17. INFORMANT <u>Springfield, Mo. Address Effie Weatherman, 1927 Monroe Ter.</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>Cerebral Hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____																			
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																			
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 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 <u>12/7/59</u> to <u>12/13/59</u> and last saw her/him alive on <u>12/13/59</u> Death occurred at <u>5:55 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>W. Debell M. D.</u> (Deputy or title)				22b. ADDRESS <u>Springfield, Missouri</u>				22c. DATE SIGNED <u>12/15/59</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/15/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cemetery</u>				23d. LOCATION (City, town, or county) <u>Springfield Missouri</u>											
24. FUNERAL DIRECTOR <u>Ralph Thieme, Springfield, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>12-28-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Metten</u>													

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 23 1962

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

Harold Futrell

Licensed Embalmer No. 5079

P. O. Address Spfd. In

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.