

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS MAR 28 1960

60-014022  
 STATE FILE NUMBER

Registration District No. 325 Primary Registration District No. 6279 Registrar's No. 6

|  |   |   |  |  |   |  |   |                                    |  |
|--|---|---|--|--|---|--|---|------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WRIGHT</b>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO.</b> b. COUNTY <b>WRIGHT</b> |   |  |   |                                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>GASCONADE</b>  |   | Length of stay in 1b  |  | c. CITY OR TOWN <b>SEYMOUR</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |                                    |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Home</b>   |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>ROUTE 1</b>       |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                    |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RAY</b> Middle <b>F.</b> Last <b>WEIHS</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>20</b> Year <b>60</b>  |   |  |   |                                    |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7-28-1893</b>   | 9. AGE (last birthday)<br><b>66</b>                                   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HR<br>Hours Min.  |                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED FARMER</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)<br><b>KANSAS CITY, MO.</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |                                    |  |
| 13a. FATHER'S NAME<br><b>JOHN C. WEIHS</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>CORA M. RECORDS</b>                                  |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>ORLAND MAE WEIHS</b>   |   |                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES WORLD WART</b>  |   |   | 16. SOCIAL SECURITY NO.<br><b>489 248 825</b>  |  | 17. INFORMANT<br><b>Mrs. Orland Mae Weihs Seymour, Mo.</b>            |  |   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>  |   |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mo</b>                                       |                                    |  |
| 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)<br><b>Post-operative repair of diaphragmatic hernia</b>  |   |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |                                    |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>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 <b>Jan 26, 1960</b> to <b>March 20, 60</b> and last saw <sup>her</sup> him <b>live</b> on <b>March 2, 1960</b><br>Death occurred at <b>11:40 p</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |  |   |  |   |                                    |  |
| 22a. SIGNATURE (Degree or title)<br><b>R. O. Callaway, MD</b>  |   |   |  | 22b. ADDRESS<br><b>Springfield Mo</b>  |   |  |   | 22c. DATE SIGNED<br><b>3/23/60</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>3/25/60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. ZION Cemetery</b>  |  |  | 23d. LOCATION (City, town, or county)<br><b>WRIGHT Co. Mo.</b>        |  |   |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>Robert Bergman Seymour, Mo.</b>   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>3-25-1960</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>Bernie J. Jones</b>  |   |                                    |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

100-10-2711

FEB 7 1961

STATEMENT BY LICENSED EMBALMER

APR 1 1960 0981 S

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 Max J. Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield

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.