

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024870

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Dr. Lurie

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 678

FILED JUL 24 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>GREENE</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>	a. STATE <b>MISSOURI</b>	b. COUNTY <b>GREENE</b>
Length of stay in 1b <b>7 YRS.</b>		c. CITY OR TOWN <b>SPRINGFIELD</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>1862 N. MISSOURI</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>CHARLES</b>	Middle <b>F.</b>	Last <b>WEILER</b>	4. DATE OF DEATH	Month <b>JULY</b>	Day <b>17</b>	Year <b>1961</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/12/84</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done or business of employer if reported) <b>SEMI-PROFESSIONAL TOWEL &amp; LINEN SERVICE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>ST. GENEVIEVE, MO.</b>	11. BIRTHPLACE (City and state or country) <b>ST. GENEVIEVE, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>PETER WEILER</b>	13b. MOTHER'S MAIDEN NAME <b>MARY KIRCHNER</b>	14. NAME OF HUSBAND OR WIFE <b>EMMA WEILER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	17. INFORMANT <b>ROBERT C. WEILER, SPRINGFIELD, MO.</b>
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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
IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b>	<b>5 Hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <b>Cerebral Arteriosclerosis</b>	<b>Several years</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) <b>Arteriosclerotic Heart Disease</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **1956** to **7/17/61** and last saw him alive on **7/16/61**  
Death occurred at **3:10 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Harold H. Lurie, M.D.</b>	(Date or title)	22b. ADDRESS <b>600 S. G. Kenstone Springfield, Mo.</b>	22c. DATE SIGNED <b>7/17/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7/19/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>VALLEY SPRINGS</b>	23d. LOCATION (City, town, or county) <b>ST. GENEVIEVE, MO.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-18-61</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Meekin</b>
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DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 ITEM NO.

JUL 24 1961

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed W. A. McCombs

Licensed Embalmer No. 2727

P. O. Address W. A. McCombs

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.