

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044334

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6274 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF W. Woodward

FILED DEC - 2 1963		1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Missouri		Length of stay in 1b <u>2 day</u>		c. CITY OR TOWN Independence, Mo Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2415 Vermont Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Gottlieb Weiss:			4. DATE OF DEATH Month 11 Day 17 Year 63		
5. SEX M		6. COLOR OR RACE W		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 3-3-1880		9. AGE (last birthday) 83		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Goodland Indiana	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Mary (Unknown)	
14. NAME OF HUSBAND OR WIFE Vesta Ann Weiss		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. [Redacted]	
17. INFORMANT Sperry R. Weiss		Address Butler, Mo.		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO (b) Cerebral Anoxia DUE TO (c) Cerebral Vascular Thrombosis 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)		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 <u>11-15-63</u> to <u>11-17-63</u> and last saw her/him alive on <u>11-16-63</u> Death occurred at <u>10 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)			22b. ADDRESS Kansas City Mo		22c. DATE SIGNED 11-18-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-18-63	23c. NAME OF CEMETERY OR CREMATORY Oakhill		23d. LOCATION (City, town, or county) (State) Butler Mo.
24. GENERAL DIRECTOR ADDRESS George C. Carson & Sons		25. DATE RECD. BY LOCAL REG. 11-18-63		26. REGISTRAR'S SIGNATURE Bessie Smith	

USE BLACK INK OR TYPEWRITER RIBBON

1957-1958

STATE OF MISSISSIPPI

and

1000

General Embalmer License No. _____
Student Embalmer License No. _____
Signature of Student Embalmer _____
Signature of Licensed Embalmer _____

STATEMENT BY LICENSED EMBALMER

11-2

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 J. T. Crowell

Licensed Embalmer No. 4904
P. O. Address H. C. Moore

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.

11-18-11
Mississippi State Board of Health
P.O. Box 1000
Jackson, Mississippi