MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3243

Do not use this space.

FILED FEB 15 1943

89 00

1. PLACE OF DEATH

(a) County Ray Registration District No. 217 98 0

(b) Township Primary Registration District No. 4446 0 Registered No.

(c) City Hardin Mo (d) Street No. St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lucinda- WEAVER

(a) Residence, No. 1 Hardin Ray Co St. [ ] 1

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	2 Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John L Weaver

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 20th 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	83	5	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bedford Bates Co. Iowa 1

FATHER

13. NAME John Rose

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know 9

MOTHER

15. MAIDEN NAME Rebecca Rose

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know 9

17. INFORMANT (ADDRESS) W. A. Tatler Hardin Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Norborne Mo DATE Jan. 30 1943

19. FUNERAL DIRECTOR (ADDRESS) John W. Knipschild Hardin Mo.

20. FILED ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28 1943

22. I HEREBY CERTIFY, That I attended deceased from Jan 23 1943, to Jan 28 1943

I last saw her alive on Jan 28 1943 Death is said to have occurred on the date stated above, at 5-30 a m.

The principal cause of death and related causes of importance were as follows:

Influenza 3 da

Date of onset Jan 24/43

Other contributory causes of importance; Acute Gastritis 1/24/43

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Marion Green, M. D.

(Address) Hardin, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1290

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number .....
Date Filed 2-13-43

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No. 2789

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E. .....

No. .....or by ....., Registered Apprentice No. .....

working under my personal supervision.

Signed John W. Krupschild.

Licensed Embalmer No. 2789

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

. No. 2B
1—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3243

Registration District No. 297 Primary Registration District No. 4446 Registrar's No.

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Hardin
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lucinda Weaver

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 25 (Day) (Year)

8. AGE: Years 83 Months 0 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Iowa (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) Jan 30 43 (b) (Registrar's signature) Mrs Chas W Shepard

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 29
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY