

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 880044102 STATE FILE NUMBER

FILED DEC - 4 1964

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Dent County</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem, Missouri</u>		c. CITY OR TOWN <u>Salem, Missouri</u>	
Length of stay in 1b <u>6 month</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Salem Rt. 4, Missouri</u>		d. STREET ADDRESS (If outside, give location) <u>Rt. 4 Salem, Missouri</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last			4. DATE OF DEATH Month Day Year
<u>Sarah Elizabeth Weible</u>			<u>Nov. 22, 1964</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1869</u>
9. AGE (last birthday) <u>95</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	11. BIRTHPLACE (City and state or country) <u>Karnes County, Texas</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Carben Alexander Seigil</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Eddings</u>	14. NAME OF HUSBAND OR WIFE <u>James Siegel Weible</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>X</u>	17. INFORMANT Address <u>Mrs. Lyman Bowers, Salem, Rt. 4, Mo.</u>
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) <u>Anterograde cardiac disease</u>			<u>Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>410-516</u>			
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 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>June 1963</u> to <u>11-21-64</u> and last saw her/him alive on <u>11-21-64</u>			
Death occurred at <u>2:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE (Degree title) <u>Martin W. Hart, M.D.</u>		22b. ADDRESS <u>Salem, Missouri</u>	22c. DATE SIGNED <u>11-28-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 24, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Weible Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Reynolds County, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>SPENCER FUNERAL HOME INC. Salem, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-28-64</u>	26. REGISTRAR'S SIGNATURE <u>M. M. Hart, M.D.</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59
1 0330
2 1330
3
4 1
5 2
6
7 1
8 0
9 4200
10
11
12 91-0
13 1-0

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 *Robert C. York*

Licensed Embalmer No. 5193

P. O. Address Jalen, N.C.

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.