

FILED FEB 21 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005233  
STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Grundy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Grundy</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Prenton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Galt</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Plattani View</u>		Length of stay in lb <u>3 wks</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAISY ALBERTA WESTON</u>			4. DATE OF DEATH Month Day Year <u>2-14-58</u>
5. SEX <u>fe</u>	6. COLOR OR RACE <u>w</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>July 28 1885</u>
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	9. AGE (In years last birthday) <u>72</u> FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Sullivan Co MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Sylvester H Todd</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Barton</u>	
14. NAME OF HUSBAND OR WIFE <u>Clifford Weston</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Address <u>Mrs Helen McNeely Prenton MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis acute cardiac insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Deceased has apoplexy about 5 yrs. ago and had been an invalid since</u>			19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>Nephritis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Flu</u>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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>2-9</u> to <u>2-14-58</u> and last saw her alive on <u>2-13-58</u> Death occurred at <u>4:00 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>BH Cullers M.D.</u>		22b. ADDRESS <u>Prenton, MO</u>	
22c. DATE SIGNED <u>2-15-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	
23b. DATE <u>2-17-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Camp Ground</u>	
23d. LOCATION (City, town, or county) (State) <u>Osgood MO</u>		24. FUNERAL DIRECTOR ADDRESS <u>PK Payne Soc Galt MO</u>	
25. DATE RECD. BY LOCAL RES. <u>2-17-58</u>		26. REGISTRAR'S SIGNATURE <u>Irene Fair</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

MAR 5 1958

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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 *P. K. Payne Jr.* .....

Licensed Embalmer No. *3400* .....

P. O. Address *Galt* .....

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.