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FILED DEC 8 1947

Registration District No. **42**

Primary Registration District No. **5134**

Registrar's No. **1418**

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

1. PLACE OF DEATH:

(a) County **Buchanan**

(b) City or town **Rural Route # 1**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Rural Route #1 Pickett Rd.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None**
(Specify whether **1**)

In this community **Lifetime**
years, months or days

3. (a) PRINT FULL NAME **Adolph J. Weidmaier**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male** **0**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Agnes Mary**

6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **July 20 1892**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	55	4	9hr.min.

9. Birthplace **Hurlinger Missouri, 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Own**

12. Name **Jacob Weidmaier**

13. Birthplace **Unknown Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Siskey**

15. Birthplace **Unknown Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Agnes Weidmaier**

(b) Address **Rural Route # 1**

17. (a) Burial **Dec. 1, 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet cemetery**

18. (a) Signature of funeral director **Norman W. J. J. J.**

(b) Address **1802 Union St. St. Joseph, Mo.**

19. (a) 12-4-47 **(b) C. C. Jenkins**
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan 11**

(c) City or town **Rural 0**
(If outside city or town limits, write "RURAL")

(d) Street No. **Rural Route #1 Pickett Rd. 0**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country *****

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **29**
year **1947** hour **2** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **Nov 17 1947** to **Nov 29 1947**
that I last saw him alive on **Nov 29**, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death **abdominal malignancy (cancer) 2 yr**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings: **46**

Of operations.....

Of autops: **none**

ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUESTED

Underline the cause of which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) **none**

(b) Date of occurrence **Jan 1946**

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

(d) 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 **0**

23. Signature **G. F. Kimball** (M. D. or other)

Address **St. Joseph, Mo.** **Date signed** **11-29-47**

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.....

..... Registered Apprentice No.

working under my personal supervision.

Signed.....

Robert Lygale

Licensed Embalmer No. *3308*

P. O. Address..... *St Joseph, Mo*

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 this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registered Information
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 1418

Registration District No. 42 Primary Registration District No. 5134

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Rural
(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
In this community..... (Specify whether
years, months or days)

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 Adolph J. Weidmaier
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased July 20 1884
(Month) (Day) (Year)

8. AGE: Years 55 Months Days If less than one day hr. min.

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

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) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 29
year 1941 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to.....
19.....; that I last saw him..... alive on..... 19.....;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to Cancer of some part of the abdomen
Other conditions (Includes pregnancy within 3 months of death)
Major findings: M.M.O. 604
Of operations.....
Of autopsy: no 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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury.....
23. Signature G. F. Kimball (M. D. or other).....
Address St. Joseph, Mo Date signed 12-26-41

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

SUPPLEMENTARY

S-3722)

all