

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.

Registration District No. 784

Primary Registration District No. 111

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Richwood
 (c) Name of hospital or institution: ST. MARYS. HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days _____

3. (a) PRINT FULL NAME JAMES DONALD WEAKLEY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife BERNICE WEAKLEY 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased APRIL 27, 1900
 (Month) (Day) (Year)

8. AGE: Years 39 Months 10 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation SALESMAN

11. Industry or business MILWAUKEE PAINT CO.

MOTHER FATHER { 12. Name JOHN F. WEAKLEY

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

14. Maiden name ANNA BRENNAN (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Bernice Weakley

(b) Address 2902 PAGE AVE

17. (a) BURIAL (b) Date thereof 3, 18, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Lawrence Muller

(b) Address 5765 Delmar Blvd.

19. (a) MAR 16 1940 (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Warren
 (c) City or town Vinita Pk
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7902 PAGE AVE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 - 1940
 year 1940 hour 11 25 minute 77 M.

21. I hereby certify that I attended the deceased from 7-14-1939 to May 15, 1940
 that I last saw him alive on 3-15-1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis - Chronic Duration 2 yrs

Due to Nephritis - Chronic

Due to Malignant Hypertension 1/2 yr

Other conditions (Include pregnancy within 3 months of death) 131

Major findings: Of operations L

Of autopsy L

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? 767
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature Leo Muller M.D. (M.D. or other) _____
 Address 810 S. Page Blvd. Date signed 3-16-40

Dr. Leo Reilly
8105 Page
Wi 1021

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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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Howard F. Rowland

Licensed Embalmer No. 3114

P. O. Address.....

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, above space should be left blank.