

No. 2  
-12-45  
-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 11 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

7103  
State File No. \_\_\_\_\_  
Registrar's No. **2012**

Registration District No. **318** Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**

(a) County St. Louis

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

(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Beatrice Weaver

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife Mack Weaver

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

7. Birth date of deceased April 13 1895  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>51</u>	<u>9</u>	<u>10</u>	hr. min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Thomas Taylor

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

14. Maiden name S. Taylor

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

16. (a) Informant MARK WEAVER

(b) Address 2030 1/2 FRANKLIN REAR

17. (a) BURIAL (b) Date thereof MAR 11 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENWOOD CEM.

18. (a) Signature of funeral director F. A. GREENE

(b) Address 2915 FRANKLIN AVE.

19. (a) FEB 27 1947 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 2030 Franklin  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 23  
year 1947 hour 11 minute 25 A.M.

21. I hereby certify that I attended the deceased from 2-3 1947, to 2-23 1947;  
that I last saw her alive on Feb. 23 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis  
Duration Undet.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy No

**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 0

23. Signature Edw. B. Williams (M. D. or other) \_\_\_\_\_

Address 2601 N Whittier Date signed 2/24/47

(Licensed Embalmer's Statement on Reverse Side)

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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

*F. C. Green*

Licensed Embalmer No

*2963*

P. O. Address

*2915 Franklin Ave*

**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.**