

FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 17101  
4517

|   |  |  |   |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>  |   | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. <b>4517</b>  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>OHIO</b>   |  |  |  | b. COUNTY _____                                     |  |
| b. CITY OR TOWN <b>SAINT LOUIS:</b>   |  | c. LENGTH OF STAY (in this place) _____  |   | c. CITY OR TOWN <b>COLUMBUS</b>  |  | d. In Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4910 WEST PINE BLV'D.</b>  |  |  |   | STREET ADDRESS (If rural, give location) <b>8348</b>   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>HARRISON</b>   |  |  | b. (Middle) <b>J.</b>   |  |  | c. (Last) <b>WEAVER</b>  |  |   |  |
| 4. DATE OF DEATH (Month) (Day) (Year)<br><b>MAY 21 1955</b>   |  |  | 5. SEX <input checked="" type="checkbox"/> <b>MALE</b>  |  |  | 6. COLOR OR RACE <b>WHITE</b>  |  |   |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>   |  |  | 8. DATE OF BIRTH <b>MARCH 30 1886</b>   |  |  | 9. AGE (In years last birthday) <b>69</b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRAV. PHYSICIAN &amp; TRAINER.</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>BASE BALL CLUBSTRY</b>   |  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>MIAMIASBURG, OHIO</b>  |  |   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |  | 13a. FATHER'S NAME <b>JOHN WEAVER</b>   |  |  | 13b. MOTHER'S MAIDEN NAME <b>ALICE AUCHER</b>  |  |   |  |
| 14. NAME OF HUSBAND OR WIFE <b>ESTELLAMAY H. WEAVER</b>   |  |  | 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. <b>498-09-3576</b>   |  |   |  |
| 17. INFORMANT'S SIGNATURE OR NAME <b>Estellamay H. Weaver</b>   |  |  | ADDRESS _____   |  |  |  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |  |  |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>ACUTE CORONARY THROMBOSIS</b> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 HOURS</b> |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |   | ANTECEDENT CAUSES<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>~</b>   |  | 19b. MAJOR FINDINGS OF OPERATION <b>~</b>  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____         |   | 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____  |  |  |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR? <b>4201</b>   |  |  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>6/20</b> 19 <b>55</b> , to <b>5/21</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>5/21</b> , 19 <b>55</b> , and that death occurred at <b>4:00 A. m.</b> , from the causes and on the date stated above. |  |  |   |  |  |  |  |   |  |
| 23a. SIGNATURE <b>J. C. Middleman</b> (Degree or title) <b>M.D.</b>   |  |  |   | 23b. ADDRESS <b>462 N. Taylor - St Louis Mo.</b>   |  |  |  | 23c. DATE SIGNED <b>5/21/55</b>                     |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>  |  | 24b. DATE <b>MAY 24 1955</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY <b>WOODLAND CEMETERY</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>DAYTON, OHIO. OHIO.</b>   |  |   |  |
| DATE REC'D BY LOCAL REG. <b>MAY 23 1955</b>   |  | REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. R. LUPTON &amp; SOMS - 7233 DELMAR BLV'D.</b>                     |  |  |  |   |  |

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

S. P. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
MAY 2 1914

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 *Arnold W. Schoene*

Licensed Embalmer No. *386*

P. O. Address *St. Louis*

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.