

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11257

FILED APR 15 1957

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State File No. _____
Registrar's No. 2898

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (If in this place) 4 yrs		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6029 Maple Av				e. STREET ADDRESS (If rural, give location) 6029 Maple Av					
3. NAME OF DECEASED (Type or Print) a. (First) Rose		b. (Middle) _____		c. (Last) WEAKLEY		4. DATE OF DEATH (Month) (Day) (Year) Mar. 24, 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug. 26, 1885			
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days		IF UNDER 2 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Abe Staley		13b. MOTHER'S MAIDEN NAME Ellen Staley		14. NAME OF HUSBAND OR WIFE Enos Weakley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Enos Weakley, 6029 Maple Av					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CHRONIC TUBERCULOSIS</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>420.1</u>						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
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? _____					
22. I hereby certify that I attended the deceased from <u>MAR 21, 1957</u> , to <u>MARCH 24, 1957</u> , that I last saw the deceased alive on <u>MAR 27, 1957</u> , and that death occurred at <u>2:35 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Orville O. White</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>1194 Hodiamont</u>		23c. DATE SIGNED <u>3-25-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>3-26-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthew</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>MAR 25 1957</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fendler Und. Co., 7420 Michigan Ave.</u>					

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

O.O. White

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& to 5 today

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.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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