

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016594

STATE FILE NUMBER

FILED MAY 8 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No. 4643

300

1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis, Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS, MO.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>25 St. Louis City Hosp. #1</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>21/1 W 3517 LUCAS</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>HARRY</i> Middle Last <i>WEEKS</i>			4. DATE OF DEATH Month <i>MARCH</i> Day <i>17</i> Year <i>1958</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG. 6 1882</i>		9. AGE (In years last birthday) <i>75</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>?????</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>??</i>	11. BIRTHPLACE (City and state or country) <i>WALES ENGLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>UNKNOWN</i>
13a. FATHER'S NAME <i>JOSEPH WEEKS</i>		13b. MOTHER'S MAIDEN NAME <i>MARTHA</i>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) <i>UNKNOWN</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT Address <i>ST. LOUIS CITY HOSP. #1.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Basilar Artery Thrombosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 Week</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral Arteriosclerosis</i>					<i>10 YRS.</i>
DUE TO (c) _____					<i>332X</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>3/5/57</i> to <i>3/17/58.</i> and last saw him alive on <i>3/17/58.</i> Death occurred at <i>1:20 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Signed or initialed) <i>John W. Stupich M.D.</i>			22b. ADDRESS <i>1515 Lafayette Ave.</i>		22c. DATE SIGNED <i>3/17/58.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4-30-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Rowland-Aker Mortuary Service</i> <i>4104 Manchester Ave. St. Louis 10, Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>APR 30 58</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith Mo</i> <i>m ds.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

**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.