

FILED MAY 19 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020377

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 1259

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>WELLSTON St. Louis</b> <b>43116</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Co. Hosp.</b>	Length of stay in 1b <b>3 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>6304 Wagner</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle <b>Weaver</b> Last <b>Weaver</b>	4. DATE OF DEATH Month <b>5</b> Day <b>4</b> Year <b>58</b>
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5. SEX <b>Female 3</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1884</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Montgo, Alabama</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Calvin Weaver, Sr.</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <b>NO</b> unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Calvin Weaver, Jr.</b> Address <b>4642 Ashland</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respirator Acting Below Lungs</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>4501</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>37 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis Congestive Heart Failure</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b>12:45 a.</b> Month, Day, Year <b>5-4-58</b>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>St. Louis, Mo.</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>5-1-58</b> , to <b>5-4-58</b> and last saw her/him alive on <b>5-4-58</b> . Death occurred at <b>12:45 a.</b> m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>Walter N. Blalock</b>	22b. ADDRESS <b>601 So. Brentwood</b>	22c. DATE SIGNED <b>5-4-58</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-9-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>E. B. Nooner</b> ADDRESS <b>1221 N. Grand</b>	25. DATE RECD. BY LOCAL REG. <b>5-8-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donda M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Clarence Croon* .....

Licensed Embalmer No. *4755* .....  
P. O. Address *1221 7th St* .....

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.