

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031104
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7480

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA City Hosp		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1361a Shawmult Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Osca r Weston			4. DATE OF DEATH Month Day Year July 29 1958
5. SEX male 2	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Feb. 1922
9. AGE (In years last birthday) 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	11. BIRTHPLACE (City and state or country) Macon, Mississippi U.S.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Will Weston	13b. MOTHER'S MAIDEN NAME Ada Harris
14. NAME OF HUSBAND OR WIFE Fannie Weston		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give year or dates of service) Yes World War II	16. SOCIAL SECURITY NO.
17. INFORMANT Fannie Weston		Address 1361a Shawmult	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic external hemorrhage. Contributory: Compound Fracture of the spine with laceration of the abdominal aorta, suffered when crushed between elevator at 3rd floor level of building at 1460 N. 1st St.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) while working about 10:32 a.m. July 29th, 1958. DUE TO (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) while working about 10:32 a.m. July 29th, 1958.		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" 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.) See above		20c. TIME OF INJURY Hour Month, Day, Year 10:32 p.m. 7-29-58	
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) warehouse	20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo.
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 11:38 A. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Joseph M. Ziemer M.D.		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 7/30/58
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 4 Aug. 1958	23c. NAME OF CEMETERY OR CREMATORY National Cem. Jeff. Bks.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR ADDRESS Reliable Funeral Sys. 1389 N. Union		25. DATE RECD. BY LOCAL REG. JUL 31 1958	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

VS NOV 2 1959

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 *John K. Cunningham*

Licensed Embalmer No. *4476*

P. O. Address *2405 Marcus*

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.