

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046487

STATE FILE NUMBER

11908

FILED DEC 22 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		4. STREET ADDRESS (If outside, give location) 5446 Thrush Ave.	
Length of stay in lb 9 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
5. NAME OF DECEASED (Type or print) DOMINIC WEIR SR.		6. DATE OF DEATH Dec. 9 1958	
First Middle Last		Month Day Year	
7. SEX male C	8. COLOR OR RACE white	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10. DATE OF BIRTH Feb. 4, 1883
11. AGE (In years from birthday) 75	12. FUNDER 1 YEAR Months Days	13. IF UNDER 24 HRS. Hours Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		15. KIND OF BUSINESS OR INDUSTRY	
16. BIRTHPLACE (City and state or country) England 4		17. CITIZEN OF WHAT COUNTRY? U.S.A.	
18a. FATHER'S NAME Michael Weir		18b. MOTHER'S MAIDEN NAME Not Known	
19. NAME OF HUSBAND OR WIFE Mary Weir		20. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
21. SOCIAL SECURITY NO. 489 20 3354		22. INFORMANT Mary Weir 5446 Thrush Ave.	
23. ADDRESS		24. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis with cerebral hemorrhage DUE TO (b) Diabetes mellitus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) 260X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 11 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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 October, 1956 to Dec. 9, 1958 and last saw her alive on Dec 8, 1958 Death occurred at 1:30A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Hakken Weir		22b. ADDRESS 5074 N. Union	
22c. DATE SIGNED 12-9-58		23a. BURIAL, CREMATION, REMOVAL (Specify) burial	
23b. DATE 12/11/58		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) St. Louis		(State) Mo.	
24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant		25. DATE RECD. BY LOCAL REG. DEC 11 1958	
26. REGISTRAR'S SIGNATURE Carl Smith MD		27. REGISTRAR'S SIGNATURE m d s	

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 *Lawrence O. Galt* .....

Licensed Embalmer No. *4999* .....

P. O. Address *St. Louis, Mo.*

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.