

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

38656

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **11357**

Township **St. Louis**

Primary Registration District No. **1003**

Registered No. **11357**

City **St. Louis** (No. **City Hospital #2**)

St. Ward)

2. FULL NAME

Willie Mae Weakley

(a) Residence. No. **4289 Sacramento** St.,
(Usual place of abode)

J.C. Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **9** yrs. mos. da.

9 yrs. mos. da.

.... mos. da.

How long in U.S., if of foreign birth? yrs. mos. da.

.... mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word)

Single

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Aug. 8, 1916

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

11

4

24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN); (STATE OR COUNTRY)

Ark.

10. NAME OF FATHER

Will Weakley

11. BIRTHPLACE OF FATHER (CITY OR TOWN); (STATE OR COUNTRY)

Miss

12. MAIDEN NAME OF MOTHER

Minnie Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY)

Ala.

14.

INFORMANT (Address)

**Anna F. Woodard
City Hospital #25**

15.

DEC 19 1927
FILED

Max C. Starosoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec. 16, 1927

17.

I HEREBY CERTIFY That I attended deceased from **9/23**, 19**27**, to **12/16**, 19**27** that I last saw her alive on **12/16**, 19**27**, and that death occurred, on the date stated above at **8:00 a.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
339

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **St. Louis**, M. D.

, 19 (Address) **City Hosp. #2**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Greenwood

DATE OF BURIAL

Dec 20 1927

20. UNDERTAKER

J.C. Thomas

ADDRESS

3111 Leclaire

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

