

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

Do not use this space.

14602

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 2003  
 City St. Louis Mo (No. 4152) Belle ave St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 3966 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Joseph S. Weatherford  
 (a) Residence No. 4152 Belle ave St. 11 Ward \_\_\_\_\_  
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**2 MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/18 19 30

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1929 to April 13 1930 that I last saw him alive on 4/18/30 at 7:15 P. M. and that death occurred, on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt. 1879

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Myocarditis Chronic  
131  
93C

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
about 50 Unknown

CONTRIBUTORY (SECONDARY) Chronic nephritis  
 (duration) about 5 yrs yrs. mos. da.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Minister  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED St. Louis Mo  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Do

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

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam  
2 mo ago  
 (Signed) Oral S. McClellan M. D.  
 . 19 (Address) 1046 1/2 Sarah

\*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.

14. INFORMANT Leora Cooper  
 (Address) 4152, W. Oselle. Pl.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
Greenwood Cem. 4-23 1930

15. FILED 21 1930 Max C. Harlan REGISTRAR

20. UNDERTAKER ADDRESS  
E. Scott 3015. Lawton ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

