

Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **1326**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Koch**
(c) Name of hospital or institution: **Robert Koch Hospital**
(d) Length of stay: In hospital or institution **3 56 Days**
In this community **3 17** years, months or days

3. (a) PRINT FULL NAME **Weathers, William**

3. (b) If veteran, name war **-** 3. (c) Social Security No. **709-09-25**

4. Sex **M** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Weathers** 6. (c) Age of husband or wife if alive **3** years

7. Birth date of deceased **Jan 1 1896**

8. AGE: Years **44** Months **6** Days **10** If less than one day hr. min.

9. Birthplace **Indiana** (City, town, or county) **Miss** (State or foreign country)

10. Usual occupation **Pullman Porter**

11. Industry or business **Railroads**

12. Name **Hub Weathers**

13. Birthplace **Vicksburg** (City, town, or county) **Miss** (State or foreign country)

14. Maiden name **Octavia**

15. Birthplace **Vicksburg** (City, town, or county) **Miss** (State or foreign country)

16. (a) Informant **Patent**

(b) Address **3436 Loleda**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **July 18 1940** (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (e) Signature of funeral director **E. H. Dancy**

(b) Address **2829 Washington Ave**

19. (a) **JUL 16 1940** (Date received local registrar) (b) **T. R. Dancy** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **-**
(c) City or town **St. Louis**
(d) Street No. **3436 Loleda**
(e) If foreign born, he long in U. S. A. **-** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **11** 15th year **1940** hour **8** minute **20** P. M.

21. I hereby certify that I attended the deceased from **July 15** 19**38** to **July 11** 19**40** that I last saw him alive on **July 11** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Pulmonary tuberculosis**

Due to **-**

Due to **-**

Other conditions **Syphilis 34** (Include pregnancy within months of death)

Major findings: Of operations **-**

Of autopsy **Bil. pul the with carcinoma; Intestinal the**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **-**
(b) Date of occurrence **-**
(c) Where did injury occur? **-** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **-**

While at work? **-** (Specify type of place) (e) Means of injury **-**

23. Signature **Hubert F. Schwartz** (M. D. or other) **1**
Address **Koch Hospital** Date signed **7/12/40**

Duration **Weeks**
PHYSICIAN **-**
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 23 1947

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Malvin Blackburn

Licensed Embalmer No.

3962

P. O. Address

2829 Washington

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 this body is not embalmed, above space should be left blank.