

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30515**
Registrar's No. **8550**

ED OCT 2 - 1943

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution **21 days**
(Specify whether years, months or days) **** 1 month; 20 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County.....
(c) City or town..... **St. Louis,**
(If outside city or town limits, write "RURAL") **117**
(d) Street No. **4179 W. Belle**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Alvin Weatherspoon Jr.**

3. (b) If veteran, name war..... No.....
3. (c) Social Security No.....

4. Sex **Male** 5. Color **Col** 6. (a) Single, widowed, married, divorced **—**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive **4** years (Day) (Year) **1943**

8. AGE: Years Months Days If less than one day
20 hr. min.

9. Birthplace **St Louis** (City, town, or county) **MO** (State or foreign country)

10. Usual occupation **Infant**

MOTHER FATHER
11. Industry or business
12. Name **Alvin Weatherspoon**
13. Birthplace (City, town, or county) (State or foreign country) **Mo**
14. Maiden name **Jenella Wells**
15. Birthplace (City, town, or county) (State or foreign country) **Mo**

16. (a) Informant **Alvin Weatherspoon**

(b) Address **4779 West Bell**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9/28/43** (Month) (Day) (Year)

(c) Place: burial or cremation **Herzlanum Mo**

18. (a) Signature of funeral director **F. A. Green**

(b) Address **2915 Franklin Ave**

19. (a) **SEP 28 1943** (Date received local registration) **J. F. Bredek** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **24**, 19**43** year hour **9** minute **00** A. M.

21. I hereby certify that I attended the deceased from **September 3, 1943** to **September 24, 1943** that I last saw him alive on **September 24, 1943**; and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity (since birth)**

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) **127**

Major findings: Of operations.....
Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 **J. R. Mery** (M.D. brother)

Address **260 Whittier** Date signed **9/25/43**

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.....

Licensed Embalmer No. 2963

P. O. Address. 2915 Franklin Ave.

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, fact should be so stated above.