

S. No. 2
DM-5-43
v. 5-17-39
I X36671

39899

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

FILED DEC 27 1944

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 10770

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. John Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town University City
(If outside city or town limits, write "RURAL")

(d) Street No. 7630 Fairham Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Daniel J. Weir.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Josephine Weir

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Nov. 12, 1892.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>1</u>	<u>4</u>	hr. min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Assistance Fire Chief

11. Industry or business University City Fire Dept.

MOTHER FATHER

12. Name James Weir

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary McGowan

15. Birthplace England
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Josephine Weir

(b) Address 7630 Fairham Ave.

17. (a) Burial (b) Date thereof Dec. 19/44.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) DEC 18 1944 (Date received local registrar)
J. Redek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16
year 1944 hour 11.32 minute A.M. M.

21. I hereby certify that I attended the deceased from Sept. 25th, 1944 to Dec. 16th, 1944
that I last saw him alive on Dec. 16th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of bladder (primary)

Due to _____

Due to 52

Other conditions (include pregnancy within 3 months of death) _____

Duration 2 yrs

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Cc. of bladder with metastases to lymph nodes

Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature Raymond (M. D. or other) _____

Address 609 Humboldt Bldg. Date signed 12-18-1944

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

Dr. Dr. Grayson Carroll,
603 Humboldt Bldg.,
537 N. Grand Blvd.,
NE. 0202.
10-1 or 4-530 P.M.

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. 3225

P. O. Address..... 1125 Hodiament 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.