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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19021

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5063

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips (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 (If outside city or town limits, write "RURAL")
(d) Street No. 4284 ~~West St Ferdinand~~ West St Ferdinand (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JAMES MERRIWEATHER

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

4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 7 (Day) 1905 (Year)

8. AGE: Years 39 Months 7 Days 28 If less than one day hr. min.

9. Birthplace (City, town, or county) Tenn (State or foreign country)
10. Usual occupation Labor
11. Industry or business

FATHER
12. Name Callier Merriweather
13. Birthplace (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Sarah Benson
15. Birthplace (City, town, or county) Tenn (State or foreign country)

16. (a) Informant Calvin Merriweather
(b) Address 4400 Kennerly ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem
18. (a) Signature of funeral director J. A. Green
(b) Address 2915 Franklin ave
19. (a) JUN 8 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4 year 1945 hour 3 ~~4~~ minute 30 P.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

23. Signature Patrick E. [illegible] (M.D. or other)
Address Dg Cr Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 G. A. Green

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

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.