

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1072

State File No. ....

Registration District No. **JAN 21 1948**

Primary Registration District No. **1003**

Registrar's No. **117**

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. Louis City Hospital 0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1**  
(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 **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **404 E. Marceau St.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **Jan.** day **4th**  
year **1946** hour **1:40** minute **A** M.  
21. I hereby certify that I attended the deceased from **12/30/45**  
\_\_\_\_\_, 19\_\_\_\_, to **1/4/46**, 19\_\_\_\_;  
that I last saw h. **im** alive on **1/4/46**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral thrombosis**  
Due to **cause undetermined**

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) **83**

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? \_\_\_\_\_

(Specify type of place)  
While at work \_\_\_\_\_ (2) Means of injury \_\_\_\_\_  
23. Signature **John F. Friedrich** (M. D. or other) \_\_\_\_\_  
Address **508 N. Grand** Date signed **1/4/46**

3. (a) PRINT FULL NAME **Sparlin Weathers**  
3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**  
4. Sex **Male** 5. Color or race **White** 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 **September 2 1944**  
(Month) (Day) (Year)

8. AGE: Years **1** Months **4** Days **2**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Nil**

11. Industry or business \_\_\_\_\_

12. Name **Unknown**

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

14. Maiden name **Mary Belle Lynch**

15. Birthplace **St. Louis Co. Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Sparlin Weathers**

(b) Address **404 E. Marceau St.**

17. (a) **Burial** (b) Date thereof **Jan. 8, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope Cemetery**

18. (a) Signature of funeral director **C. Hoffmeister U. & L. Co.**  
**7812 S. Broadway**

(b) Address \_\_\_\_\_

19. (a) **JAN 5 1946** **John F. Friedrich**  
(Date received from registrar) (Registrar's signature)

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

3200

**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 Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 7814 S. Broadway

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb  
Registrar's No. 112

Registration District No. 318

Primary Registration District No. 1003

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:  
(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)

3. (a) PRINT FULL NAME Sparlin Weather

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

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

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

7. Birth date of deceased Sept 2  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 1 2 3 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Jan 5 1946 (b) J. F. Bredek  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 5 Year 1946 hour..... minute..... M.

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

Due to.....  
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: 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) (e) Means of injury.....

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

Address..... Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3255

JAN 31 1946

1072