

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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: St. Louis City Hospital  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12 days  
(Specify whether \_\_\_\_\_)

In this community 36 years  
years, months or 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")  
 (d) Street No. 3705 South Main Street  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME TILLIE WEIR

3. (b) If veteran, nil name war \_\_\_\_\_  
 3. (c) Social Security none No. \_\_\_\_\_

4. Sex F / W 5. Color or W race \_\_\_\_\_  
 6. (a) Single, widowed, married, M divorced \_\_\_\_\_  
 6. (b) Name of husband or wife Herman  
 6. (c) Age of husband or wife if 78 years alive \_\_\_\_\_

7. Birth date of deceased March 24, 1878  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 5  
 year 1947 hour 2:50 minute P M.  
 I hereby certify that I attended the deceased from December 24  
 1946 to January 5 1947  
 that I last saw her alive on January 5 1947  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
68 9 11 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Arteriosclerotic Heart Disease  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 93d  
(Include pregnancy within 3 months of death)

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

10. Usual occupation house-wife

PHYSICIAN \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER { 12. Name Richard Hancock  
 { 13. Birthplace ? Kentucky  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name UNKNOWN  
 { 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Herman Weir  
 (b) Address 3705 South Main Street

17. (a) burial (b) Date thereof 1-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Pacific, Missouri

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

23. Signature W. D. Fitzgerald (M. D. or other) \_\_\_\_\_  
 Address 1515 Lafayette Avenue Date signed 1/6/47

18. (a) Signature of funeral director A.W. McLaughlin  
 (b) Address 2301 Lafayette Av. St. Louis, Mo.

19. (a) JAN 7 1947 (b) J.F. Bresch  
(Date received local registrar) (Registrar's signature)

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

11-11-64

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**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..... *W Cooper* .....

Licensed Embalmer No..... *3830* .....

P. O. Address..... *2301 Lafayette 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.**