

MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **1608**
 Registrar's No. _____

Registration District No. **318** Primary Registration District No. **100**

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: Peoples Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 days
 In this community 20 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Cutee Merriweather

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

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Willie Merriweather 6. (c) Age of husband or wife if alive 37 years
 7. Birth date of deceased May 12 1913
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 9 1 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Willie Lewis

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

14. Maiden name Nora Smith

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

16. (a) Informant Willie Merriweather

(b) Address 2402a Belleglade

17. (a) Burial (b) Date thereof 2-18-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Avenue

19. (a) Feb 17 1948 (b) J. F. Bradeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County bas
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2402a Belleglade
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 13
 year 1948 hour 4 minute 55 P. M.

21. I hereby certify that I attended the deceased from February 6, 1948, to Feb 13, 1948
 that I last saw her alive on Feb 13, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative shock
 Due to Exploratory operation on 2-12-48

Due to _____
 Other conditions (Include pregnancy within 3 months of death) 137

Major findings: Bilateral pyo-salpinx
 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 0

23. Signature L. Elizabeth Combs (M. D. or other) M.D.
 Address 4602a Page Blvd Date signed _____

Duration 29 hours
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

John K. Cunningham

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

John K. Cunningham

Licensed Embalmer No. 4076

P. O. Address. 4107 Finney Avenue

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.