

308  
47  
39  
9906

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

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
**FILED AUG 12 1948**  
Registration District No. **318**

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. **1003**

State File No. **24820**  
Registrar's No. **6913**

**1. PLACE OF DEATH:**  
(a) County.....  
(b) City or town **St Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Homer G Phillips Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **8 months**  
(Specify whether  
In this community **7 yrs**  
years, months or days)

3. (a) PRINT FULL NAME **Rosie Weaver**  
3. (b) If veteran, name war **-----**  
3. (c) Social Security No. **None**

4. Sex **Female** 3  
5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced **Widowed** 2  
6. (b) Name of husband or wife **Tom Weaver**  
6. (c) Age of husband or wife if alive **-----** years  
7. Birth date of deceased **March 2 1892**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<b>56</b>		<b>5</b>	<b>1</b>	hr. min.

9. Birthplace **Tennessee, Macon**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business.....

MOTHER FATHER  
12. Name **Unknown**  
13. Birthplace **"**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **"**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter J. Fullum**  
(b) Address **1939 Biddle St.,**

17. (a) **Burial** (b) Date thereof **8-7-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem.**

18. (a) Signature of funeral director **S. Wade**

(b) Address **4202 Finney Avenue**

19. (a) **AUG 6 - 1948** (b) **J. F. Bredack**  
(Date received local registrar) (Registrar's signature)

**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. **3226 Hickory**  
(If rural, give location)  
(e) Citizen of foreign country? **18** (Yes or No)  
If yes, name country.....

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month **August** day **3**  
year **1948** hour **6** minute **30** P.M.

21. I hereby certify that I attended the deceased from **December 3, 1947** to **August 3, 1948**  
that I last saw her alive on **August 3, 1948**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease**  
Duration **Unk.**

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

While at work (Specify type of place) (e) Means of injury **17**

23. Signature **J. Daniel** (M. D. certificate)  
Address **2601 N Whittier** Date signed **8-4-48**

(56)  
189

*now*

**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

*Melvin E. Green*

Licensed Embalmer No. *4498*

P. O. Address. *St. Louis*

**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.**