

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>St. Louis</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Hannover, St. Louis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>St. Louis</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Hannover Phillips Hospital</i>		d. STREET ADDRESS (If rural, give location) <i>1701 Harrison St. D</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>JOANN</i> b. (Middle) <i>Williams</i> c. (Last) <i>Weaver</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>Feb, 13 49</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Aug 31-1915</i>	9. AGE (In years last birthday) <i>33</i>	IF UNDER 1 YEAR Months Days <i>0 0</i>	IF UNDER 24 HRS. Hours Min. <i>0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>private family</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Palestine Ark</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>

13a. FATHER'S NAME <i>Henry Williams</i>		13b. MOTHER'S MAIDEN NAME <i>Chera McCloster</i>		14. NAME OF HUSBAND OR WIFE <i>Willie Weaver</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <i>Willie Weaver</i> ADDRESS <i>1701 Harrison</i>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Bronchitis Asthma</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at *6:30 pm.*, from the causes and on the date stated above.

23a. SIGNATURE <i>Joseph M. Turner</i> (Degree or title) <i>Deputy Coroner 3</i>		23b. ADDRESS <i>1308 Clark</i>		23c. DATE SIGNED <i>2/14/49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removed</i>		24b. DATE <i>2-18-49</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Palestine Ark</i>	
DATE REC'D BY LOCAL REG. <i>FEB 14 1949</i>		REGISTRAR'S SIGNATURE <i>J. B. Parater</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Jackson Tom Home</i> ADDRESS <i>2649 Delmon</i>	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Edward G. Flynn

Licensed Embalmer No. _____

P. O. Address _____

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.

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