

FILED NOV 5 1949

STANDARD CERTIFICATE OF DEATH

State File No. 35686
9123

318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 07			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 7 Mos		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4659 Cottage Ave				d. STREET ADDRESS (If rural, give location) 4659 Cottage Ave			
3. NAME OF DECEASED (Type or Print) George		a. (First) George		b. (Middle) M.		c. (Last) Weathers	
4. DATE OF DEATH Oct 21st 1949		5. SEX male		6. COLOR OR RACE col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 12-27-1900		9. AGE (In years last birthday) 48		10. MONTHS 9		11. UNDER 1 YEAR Days 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Grenada Mississippi		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Matt Weathers		13b. MOTHER'S MAIDEN NAME Pauline Davis		14. NAME OF HUSBAND OR WIFE Marion Weathers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 428-36-7406		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Maud Riley 4659 Cottage Ave			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 775				INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION see 1				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) Hto Miss			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 157K			
22. I hereby certify that I attended the deceased from 10-6, 1949, to 10-21, 1949, that I last saw the deceased alive on 10-21, 1949, and that death occurred at 10:25 m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Albert Kaylan, MD				23b. ADDRESS 607 N. Grand		23c. DATE SIGNED 10-22-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct 24-1949		24c. NAME OF CEMETERY OR CREMATORY Grenada		24d. LOCATION (City, town, or county) (State) Miss	
DATE REC'D BY LOCAL REG. OFF. OCT 24 1949		REGISTRAR'S SIGNATURE J. B. Faraster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Bell Ave			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

S. J. Watson

Signed.....
Student Embalmer

Licensed Embalmer No. *2698*

P. O. Address *2769 d harte*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.