FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35687

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8770

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 7 hrs. 45 min
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis Children's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 77
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Portageville
d. STREET ADDRESS (If rural, give location): N.C.

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Jane
c. (Last): Weaver

4. DATE OF DEATH (Month) (Day) (Year): October 11 - 1949

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): /
8. DATE OF BIRTH: December - 5-1948
9. AGE (In years last birthday): If under 1 year: Months 10, Days 6; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Portageville - Mo.
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Connie Elvis Weaver
13b. MOTHER'S MAIDEN NAME: Nell Clement
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Connie C. Weaver - Portageville Mo.

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) Histoplasmosis — INTERVAL BETWEEN ONSET AND DEATH: 3-4 months

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.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

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) 29 (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: 1345

22. *I hereby certify that I attended the deceased from* 10 - 11, 1949, *to* 10-11, 1949, *that I last saw the deceased alive on* 10-11, 1949, *and that death occurred at* 11 15 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm. G. Klingberg MD
23b. ADDRESS:
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 10-12-49
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Lilbourn, Mo.

DATE REC'D BY LOCAL: OCT 12 1949
REGISTRAR'S SIGNATURE: J. B. Lassiter
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: L. M. Hill Lilbourn, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.