

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16350

FILED APR 18 1953

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State File No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. **2892**

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE _____ b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St Louis MO**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St Louis MO 2729**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Homer Phillip Hospital**

d. STREET ADDRESS (If rural, give location) **22 2132 Randolph Street**

3. NAME OF DECEASED
a. (First) **John** b. (Middle) **Weaver** c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year) **3-13-1953**

5. SEX **Male**

6. COLOR OR RACE **Cauc**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **married**

8. DATE OF BIRTH **not known**

9. AGE (In years) (as birthday) **59**
If under 1 year: Months _____ Days _____
If under 1000: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer**

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **Crawford Miss**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **not known**

13b. MOTHER'S MAIDEN NAME **not known**

14. NAME OF HUSBAND OR WIFE **Willie Bee Weaver**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Willie Bee Weaver 2132 Randolph**

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) **Broncho pneumonia; cont'd**
ANTECEDENT CAUSES **Split thickness burns of thigh and legs, when deceased was working night in lat at 2134 Randolph St on July 15 1953 at about 1:08 pm**
II. OTHER SIGNIFICANT CONDITIONS **Conditions contributing to the death but not related to the disease or condition causing death.**

INTERVAL BETWEEN ONSET AND DEATH _____

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION **no accident**

20. AUTOPSY? YES NO

21a. ACCIDENT (Specify) **Accident**

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, etc.) **St**

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) **St Louis MO**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) **July 15 53 1:08 pm**

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **E9160**

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 _____ m., from the causes and on the date stated above.

23a. SIGNATURE **Patrick E Taylor** (Degree or title) **Coroner**

23b. ADDRESS **1300 Clark**

23c. DATE SIGNED **3 16 53**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**

24b. DATE **3-17-53**

24c. NAME OF CEMETERY OR CREMATORY **Greenwood**

24d. LOCATION (City, town, or county) (State) **St Louis Co, MO**

DATE REC'D BY LOCAL REG. **MAR 16 1953**

REGISTRAR'S SIGNATURE **J. Earl Smith, MD**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **A.L. Beal and Co. 4303 Delmar**

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 _____

working under my personal supervision.

Student Embalmer No.

Signed:
Student Embalmer

Signed *Daniel W. Doyle*

Licensed Embalmer No. *4802*

P. O. Address *St. Louis, Mo.*

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.