

FILED JAN 17 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3091

State File No. ....

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **107**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>107</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Romer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>25 1400 A. Biddle Street</b> <span style="float: right;">2259</span>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Sidney</b>		b. (Middle) _____		c. (Last) <b>Weaver</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1 1 56</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>10-13-1910</b>	
9. AGE (In years last birthday) <b>45</b>		IF UNDER 1 YEAR Months <b>2</b>		IF UNDER 1 YEAR Days <b>18</b>		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Smith Weaver</b>		13b. MOTHER'S MAIDEN NAME <b>Bessie ?</b>		14. NAME OF HUSBAND OR WIFE <b>Chardie Weaver</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Charlie Weaver 1400 A. Biddle St.</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Sub Arachnoid Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Hypertension</b> 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.				INTERVAL BETWEEN ONSET AND DEATH <b>12-2-55</b>  <b>Dec 54</b>	
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) <b>330 X</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		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 <b>12-6</b> , 1955, to <b>1-1</b> , 1956, that I last saw the deceased alive on <b>1-1</b> , 1956, and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>R. Sheard, M.D.</b>				23b. ADDRESS <b>2702a Franklin</b>		23c. DATE SIGNED <b>1-4-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-7-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>JAN 5 1956</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ellis Funeral Home, Inc. 2820 Stoddard St.</b>			

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 .....  
Signature of Student Embalmer

Signed *Fulton E. Calk* .....

Licensed Embalmer No. *419*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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