

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019950  
STATE FILE NUMBER

FILED MAY 23 1958

318

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5177

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY                                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>ST. LOUIS, MISSOURI</u>  |                                  | c. CITY OR TOWN <u>St. Louis</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>   |                                  | d. STREET ADDRESS (If outside, give location)<br><u>4222 MARGRITA</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>BERTHA</u> Middle <u>NMN</u> Last <u>MERRIWEATHER</u>  |                                  | 4. DATE OF DEATH<br>Month <u>MAY</u> Day <u>15</u> Year <u>1958</u>   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-1-1892</u>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |                                  | 9b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   | 9c. AGE (In years)<br>1 year Birthdays <u>65</u><br>IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____<br>IF UNDER 24 HRS. _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Brownville Tenn.</u>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |                                  | 13. FATHER'S NAME<br><u>unk</u>   |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>unk</u>   |                                  | 14. NAME OF HUSBAND OR WIFE<br><u>Alexander Merriweather</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>unk</u>   | 17. INFORMANT<br>Address<br><u>Fred Merriweather - 4222 MARGRITA</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CHRONIC PYELONEPHRITIS</u>  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>UNKNOWN</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |                                  |   | <u>600.0</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____ Year _____<br>a.m. _____ p.m. _____   |                                  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE  |
| 21. I attended the deceased from <u>APRIL 25, 1958</u> to <u>MAY 15, 1958</u> and last saw <sup>her</sup> him alive on <u>MAY 15, 1958</u><br>Death occurred at <u>7:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |
| 22a. SIGNATURE<br><u>C. Demillion M.D.</u> (Degree or title)  |                                  | 22b. ADDRESS<br><u>BARNES HOSPITAL</u>  | 22c. DATE SIGNED<br><u>5/16/58</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>5-19-58</u>      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Brownville Tenn.</u>   | 23d. LOCATION (City, town, or county) (State)  |
| 24. FUNERAL DIRECTOR<br><u>J. McClendon</u> ADDRESS<br><u>4535 Washington</u>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><u>MAY 16 1958</u>  | 26. REGISTRAR'S SIGNATURE<br><u>J. Earl Smith, M.D.</u><br>S.P.  |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Arthur L. Herliand* .....

Licensed Embalmer No. *4221*...  
P. O. Address *3100 Eastern*.....

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.