

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023692

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1608

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Wellston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u>		Length of stay in 1b <u>5 months</u>	d. STREET ADDRESS (If outside, give location) <u>1332 Union Boulevard</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Virginia</u> Last <u>Weir</u>			4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1875</u>		9. AGE (In years last birthday) <u>84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Albert Weir</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Cavanaugh</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
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 Address <u>Mr. Lawrence W. Weir, brother.</u> <u>1109 S. Berry Rd., Webster Groves 19, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>			<u>Years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diabetes Mellitus</u>		<u>4 years</u>
	DUE TO (c) <u>Chronic Br. Syndrome Assoc. with Cerebral Arterio-</u>		<u>sclerosis</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260 X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

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 Hour <u>3:30</u> Month <u>10</u> Day <u>10</u> Year <u>59</u> 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 7-10-59 to 6-14-59 and last saw her/him alive on 6-14-59  
Death occurred at 3:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph A. Costino, M.D.</u>	(Degree or title)	22b. ADDRESS <u>2407 N. Broadway St. Louis</u>	22c. DATE SIGNED <u>6/14/59</u>
--	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>	23b. DATE <u>6-16-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>	23d. LOCATION (City, town, or county) <u>St. Louis Mo.</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Em. S. Stewart</u>	ADDRESS <u>1325 Union</u>	25. DATE RECD. BY LOCAL REG. <u>6-15-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy</u>
---	------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Stanley H. Dimp*

Licensed Embalmer No. *4119*

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.