

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 0 6 4

Registration District No. XC-2434 572 SL 5829

211706

STATE FILE NUMBER

Registration District No. FILED VS JAN - 1 1960

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N. Grand, St. Louis, Mo.</u>		Length of stay in 1b <u>245 days</u>	c. CITY OR TOWN <u>St. Louis</u> 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>Vet. Adm. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3731 Blow Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle _____ Last <u>WEAVER</u>			4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/86</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>structural</u>		11. BIRTHPLACE (City and state or country) <u>Columbus, Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>JOHN WEAVER</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH JARRETT</u>		14. NAME OF HUSBAND OR WIFE <u>MINNIE WEAVER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES SPAW</u>		16. SOCIAL SECURITY NO. <u>493-05-9282</u>		17. INFORMANT Address <u>VA Hosp. Records, St. Louis, 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 <u>4 YEARS</u>
IMMEDIATE CAUSE (a) <u>CARCINOMA OF LARYNX (RIGHT)</u>				
DUE TO (b) _____				
DUE TO (c) _____				

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____		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.) <u>VA</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>		COUNTY _____	STATE _____
21. I attended the deceased from <u>4/14/59</u> to <u>12/15/59</u> and last saw <u>him</u> alive on <u>12/15/59</u> Death occurred at <u>3:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <u>Dean W. Gray</u> (Degree or title) <u>M.D. DEAN W. GRAY</u>		22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>		22c. DATE SIGNED <u>12/15/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec. 18, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	
23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>WACKER-HELDERLE-3634 Gravois Ave.</u>			
25. DATE RECD. BY LOCAL REG. <u>DEC 17 1959</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of 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 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.