

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS MAR 14 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2099** STATE FILE NUMBER **60-009044**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ma. St. Louis</b>		Length of stay in lb <b>8 mo. 1 wk.</b>	c. CITY OR TOWN <b>FERGUSON, Mo.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>334 Carson Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle _____ Last <b>Weber</b>	4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>60</b>
---	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/24/94</b>	9. AGE (last birthday) <b>65</b>	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) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Miss.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
---	--	--	--

13a. FATHER'S NAME <b>Ike Weber</b>	13b. MOTHER'S MAIDEN NAME <b>Annie Weber</b>	14. NAME OF HUSBAND OR WIFE <b>Rebecca Weber</b>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>Susie Poston, 5938 Romaine P</b> Address _____
---	----------------------------------	---

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) <b>Metastatic Carcinomatosis</b>	DUE TO (b) <b>177X</b>	<b>8 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <b>Carcinoma of Breast</b>	<b>8 mo.</b>
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

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.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
--	--	--

21. I attended the deceased from <b>6-15-59</b> to <b>2-20-60</b> and last saw her/him alive on <b>2-20-60</b> Death occurred at <b>1:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>	22b. ADDRESS <b>5800 Praena</b>	22c. DATE SIGNED <b>2/20/60</b>
--	------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/24/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Com.</b>	23d. LOCATION (City, town, or county) (State) <b>Berkeley City, Mo.</b>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Cunningham &amp; Moore, 2405 Marcus</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
--	--	--

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

*John K. Cunningham*

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus A

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.