MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6847

1. PLACE OF DEATH

County.....

Township.....

City St. Louis (No. 3421 Louisiana ave St. ..... Ward)

Registration District No. 791

Primary Registration District No. 1003

File No. .....

Registered No. 2109

2. FULL NAME Emma M. Weber

(a) Residence. No. 3421 Louisiana ave 16 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emil J. Weber

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 31-1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	68		28	

8. OCCUPATION OF DECEASED 82A

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis

PARENTS

10. NAME OF FATHER Michael Seebeck

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Walter W. Weber
(Address) 3421 Louisiana ave

15. MAR -3 1927 FILED ....., 19.... Max C. Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-10, 1927, to 2-28, 1927 that I last saw her alive on 2-28, 1927, and that death occurred, on the date stated above, at 6 45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorage
Apoplexy

(duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (SECONDARY) 74 a1

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) Charles C Drace, M. D

Mar 2, 1927 (Address) 3417 S Grand

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New St Pauls Churchyard	Mar 3 1927
20. UNDERTAKER	**ADDRESS**
Wacker-Helderle	2331 S Bdwy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD