LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

10180

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

791

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 2766

City St. Louis (No. Mo. Bap Sanit St. ..... Ward)

2. FULL NAME Elmer Weiss

(a) Residence. No. 3741a Rutger St., 18 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 2, 1919

7. AGE: Years 7, Months 4, Days 19. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at school
(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: Samuel Weiss
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Austria
12. MAIDEN NAME OF MOTHER: R. Ladinsky
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Russia

14. INFORMANT (Address): A. Weiss N.B. 3741a Rutger

15. FILED MAR 21 1927 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 21 1927

17. I HEREBY CERTIFY, That I attended deceased from Mch 13, 1927, to Mch 21, 1927, that I last saw him alive on Mch 20, 1927, and that death occurred, on the date stated above, at 3:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Meningitis
(from Otitis media)
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Otitis media about (duration) yrs. mos. 14 ds.

86a

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 3741a Rutger

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Spinal puncture

(Signed) D. C. Todd, M. D.

3/21, 1927 (Address) 4503 Page

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Chesed Shel Emeth
DATE OF BURIAL: 3/21 1927

20. UNDERTAKER: H. B. Berger
ADDRESS: 4715 McPherson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY.....
(SECONDARY)

.....(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)....., M. D

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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