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

Do not use this space.

7081

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St Louis (No. 5600 Arsenal St. ..... Ward)

File No. ..... Registered No. 2051

2. FULL NAME LESTER WIEST

(a) Residence. (Usual place of abode) No. 1522a S. Broadway (Rear) St., 23 Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 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) June 12 - 1924

7. AGE: Years 3 | Months 8 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(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) Mo

PARENTS

10. NAME OF FATHER Lester Wiest

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Ray Haper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14. INFORMANT Mother L. Turner

(Address) Same 5600 Arsenal

15. FILED FEB 21 1928 Mark Starnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb - 23 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb - 11, 1928, to Feb - 23, 1928 that I last saw alive on Feb - 23, 1928, and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Laryngitis, Acute, 12 days

Stenosis of Larynx 8 days

non Diphtheritic

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis, Acute

Bronchopneumonia (duration) Secondary 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1522 a S. Broadway (Rear)

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2/15/28

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) George H. Garrison, M. D.

, 19 (Address) ISOLATION HOSPITAL

*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: New St Marcus Cemetery

DATE OF BURIAL: Feb 25 1928

20. UNDERTAKER: A. W. McLaughlin Mrs.

ADDRESS: 1631 Mo. Ave

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.

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