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

Do not use this space.

38420

1. PLACE OF DEATH

County..... Registration District No. 791

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

City St Louis No. 12099 Sidney St. ..... Ward)

File No.....

Registered No. 11036

2. FULL NAME Albert Gustave Weekler

(a) Residence. No. 12099 Sidney St., 23 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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-6-1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	65	8	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Belt Maker
(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) Mississippi

PARENTS

10. NAME OF FATHER Adolph Weekler

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

12. MAIDEN NAME OF MOTHER Amanda Effinger

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

14. INFORMANT Edward Weekler
(Address) 12099 Sidney St St Louis Mo

15. FILED 11-19-1928 Mat O'Stanley
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 10th 1928

17. I HEREBY CERTIFY, That I attended deceased from December 28th, 1926, to November 10, 1928 that I last saw h.a.s.n. alive on November 9, 1928, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis
Uremia
(duration) several yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Chronic Arteriosclerosis
(duration) several yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Lawrence Thurman, M. D
11/10, 1928 (Address) 1808 Virden St.

*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
Nash Pickers Cem	11-12 1928
20. UNDERTAKER	**ADDRESS**
Weeks Bros	2201 Ro Grand

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 UNFADING INK—THIS IS A PERMANENT RECORD