

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

Do not use this space.

16436

1. PLACE OF DEATH

County.....
Township.....
City Jefferson No. 5800 Arsenal St.

Registration District No. 791
1003
Primary Registration District No.

File No.
Registered No. 4532
St. Ward)

2. FULL NAME

Henry Weber
(a) Residence. No. 2209 Chateau ave 22 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4 - 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64 1864 9 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labourer
(b) General nature of industry, business, or establishment in which employed (or employer) 11
(c) Name of employer

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

10. NAME OF FATHER Henry Weber

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Mrs Marie Coffinger
5800 Arsenal St

15. FILED 10 1929 REGISTRAR H. C. Stanley

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) April 18 1929

17. I HEREBY CERTIFY, That I attended deceased from February 26, 1929, to April 18, 1929, that I last saw him alive on April 17, 1929, and that death occurred, on the date stated above, at 1 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Chronic Nephritis
131
93C (duration) 4? yrs. - mos. - da.
101

CONTRIBUTORY (SECONDARY) Senility (duration) 4-8? yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH no

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) E. J. Schmor, M. D.

, 19 (Address) 5600 Arsenal

*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 Calvary Cemetery DATE OF BURIAL April 19 1929

20. UNDERTAKER E. J. Schmor ADDRESS 3125 Lafayette

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 FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

