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

Do not use this space.

10373

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St Louis Mo (No. Christian Hosp ..... St. ..... Ward)

File No. ..... Registered No. 2352

2. FULL NAME Roman H. Weber

(a) Residence. No. 4406 Florissant St., 7 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 23 - 1892

7. AGE	YEARS.	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	37	9	10	

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

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

PARENTS

10. NAME OF FATHER Henry Weber

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Yetta Soch.

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

14. INFORMANT Mattie Weber.
(Address) 4406 Florissant St.

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927 to March 5, 1930 that I last saw him alive on March 5, 1930, and that death occurred, on the date stated above, at 1:30 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aortic regurgitation
Mitral regurgitation
Nephritis (duration) 15 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Acute articular Rheumatism
Sepsis (duration) ? 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? Physical Exam
(Signed) R.M. Elbaum, M. D.
, 19 (Address) 4356 Morne.

*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 Mt. Lebanon — DATE OF BURIAL Mar 8 1930

20. UNDERTAKER Ky Leidner Und Co — ADDRESS 1417 N. Market St.

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