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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791

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

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

File No. 28283

Registered No. 8133

2. FULL NAME John Weber

(a) Residence. No. 5347 Rubin ave St., 7 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	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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 18th 1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
58		7	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stove Moulder

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Joseph Weber

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

12. MAIDEN NAME OF MOTHER Anna Kulbridge

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

14. INFORMANT Julia Weber
(Address) 5347 Rubin ave

15. AUG 1 1930 FILED, 19.... Mary O'Hanlon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-12-1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 12, 1930, that I last saw h. alive on Aug 11, 1930, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Thrombosis left cerebral artery (Arteria Sclerosis)

Chronic (duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis + Nephritis

Chronic (duration) 2 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 Lab

(Signed) F C Loeliermeyer, M. D.

8-13, 1930 (Address) 3945 N 11 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 Friedens Cem

DATE OF BURIAL Aug 15th 1930

20. UNDERTAKER Edward Koch

ADDRESS 3514 Ivy

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.