

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

Do not use this space.

34405

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis, Mo.* (No. *St. Luke's Hosp.*)

Registration District No. **791**
Primary Registration District No. **092**

File No.....
Registered No. **9762**
St..... Ward.....

2. FULL NAME

Mr. Roland B. Weis

(a) Residence. No. *3730 Utah Place* St. *16* 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Aug. 1-1903</i>		
7. AGE	YEARS	MONTHS
<i>27</i>	<i>2</i>	<i>11</i>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Dentist</i> (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) *Missouri*

PARENTS

10. NAME OF FATHER <i>Mr. Wm A. Weis</i>
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) <i>Missouri</i>
12. MAIDEN NAME OF MOTHER <i>Bertha Hoening</i>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) <i>Missouri</i>

14. INFORMANT *Mr. Wm A. Weis*
(Address) *3730 Utah Place*

15. FILED *14* 19 *19* *Nov 6 Starkloff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1. **1**

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

17. *No Physician Attended*
HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at *4:10 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries (Fractured Skull) Auto driven by deceased Colliding with Safety Zone

CONTRIBUTORY (SECONDARY) *Fractured Skull*
St. Louis Mo. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Accident*
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....
WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) *J. W. Kerner, M.D.*
10/13 1930 (Address) *Dep. Corv*

*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 *Sunset Burial Pk.* DATE OF BURIAL *10-14 1930.*

20. UNDERTAKER *Zelenschein Bros. 2623 Cherokee 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

