

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

Do not use this space.

20068

File No. 6102

Registered No. St. Ward

1. PLACE OF DEATH

County Registration District No. **791**
Township Primary Registration District No. **103**
City **ST LOUIS** (No. **DE PAUL HOSPITAL**)

2. FULL NAME **KAJETAN WIESLER**

(a) Residence. No. **4027 N. 20TH** St. **12** 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 **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **WIDOWER**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **SEP. 17TH 1878**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 **8** **12**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **BREWERY WORKER**
(b) General nature of industry, business, or establishment in which employed (or employer) **58**
(c) Name of employer **ANHEUSER BUSH BREW.**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **AUSTRIA HUNGARIA**

10. NAME OF FATHER **JOHN WIESLER**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **AUSTRIA HUNGARIA**

12. MAIDEN NAME OF MOTHER **NOT KNOWN**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **AUSTRIA HUNGARIA**

14. INFORMANT **John Wiesler** (Address) **4027 N. 20th St.**

15. FILED **311 1931** REGISTRAR **Mat C. Starn**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 29 1931**

17. I HEREBY CERTIFY, That I attended deceased from **May 15th 1931**, to **May 29 1931**, that I last saw him alive on **May 29 1931**, and that death occurred, on the date stated above, at **3:30 P.M.**

82A THE CAUSE OF DEATH* WAS AS FOLLOWS:

87 Cerebral Hemorrhage
Haemiplegia

(duration) yrs. mos. ds. CONTRIBUTORY (SECONDARY) **Arterio Sclerosis**

(duration) yrs. mos. ds. 18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF

20. WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS **Autopsy**

(Signed) **J. Starn** M. D.

. 19 **274 15th Grand** (Address)

*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

Calvary Cemetery **June 1st 1931**

20. UNDERTAKER ADDRESS

Edward Hoch **3516 N 14th**

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.

