

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.

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

Do not use this space.

29437

1. PLACE OF DEATH

County Registration District No. **791**
 Township Primary Registration District No. **1003**
 City **St. Louis** (No. **2516** - **N. Garrison Ave** St. **8423** Ward)

2. FULL NAME

Scott P. D. Wees
 (a) Residence, No. **2516 Garrison Ave 20** Ward. (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

SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>	
	5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Alma D. Wees</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan. 20 - 1889</i>			
7. AGE	YEARS <i>49</i>	MONTHS <i>6</i>	DAYS <i>12</i>
	IF LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Day Laborer</i>		
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Public Service Co.</i>		
	10. Date deceased last worked at this occupation month, and year <i>Public Service Co.</i>		
11. Total time (years) spent in this occupation			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo.</i>			
FATHER	13. NAME <i>Edward D. Wees</i>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo.</i>		
MOTHER	15. MAIDEN NAME <i>Sophie Smith</i>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo.</i>		
17. INFORMANT (ADDRESS) <i>Alma D. Wees 2516 N. Garrison Ave</i>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Summit Burial Park</i> DATE <i>Aug 11 1931</i>			
19. UNDERTAKER (ADDRESS) <i>Wacker, Helmer 2331 S. Broadway</i>			
20. FILED <i>AUG -4 1931 Max C. Stanley Registrar</i>			

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 1 1931*

22. I HEREBY CERTIFY, That I attended deceased from *July 6 1928* to *Aug 1 1931*

I last saw him alive on *July 31 1930* Death is said to have occurred on the date stated above, at *12:30 p.m.*

The principal cause of death and related causes of importance were as follows:

Pericarditis - Chronic with effusion Date of onset *Mar. 1927*

Other contributory causes of importance:

Myocarditis - Subacute *May 1931*

Name of operation Date of
 What test confirmed diagnosis *Clinical Laboratory* Was there an autopsy? *No.*

23. If death was due to external causes (accident, suicide, or homicide), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify *Prickstauer* (Signed) *Prickstauer*, M. D.
 (Address) *3147 So. Jefferson*

