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.

DEC'D NOV 16 1938

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

791

34066
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 9052
(c) City St. Louis Mo. (d) Street No. St. Anthony Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth Rauh Weinel
(a) Residence, No. 3706 A Connecticut St. St. 16
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14. 1861

7. AGE: YEARS ~~78~~ 77 | MONTHS | DAYS 1 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

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

FATHER
13. NAME Joseph Beirman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Frank Rauh 3706 A Connecticut St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE S. S. Peter & Paul DATE Oct 18 1938

19. FUNERAL DIRECTOR (NAME) Thos Kutis
(ADDRESS) 2906 Gravois Ave.

20. FILED ..... 19 ..... J F Bredeck
Local Registrar.
OCT 17 1938

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 15th 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct. 2nd 1938, to Oct. 15 1938
I last saw her alive on Oct. 15 1938. Death is said to have occurred on the date stated above, at 11 P m.
The principal cause of death and related causes of importance were as follows:

Acute perforated Gangrenous Appendicitis — Date of onset 10/1/38

Other contributory causes of importance:

Name of operation Appendectomy Date of 10/3/38
What test confirmed diagnosis? Lab. Was there an autopsy? no

23. If death was due to external causes (violence), 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? no
If so, specify .....
(Signed) [signature] M. D.
(Address) 3548 S Grand

(Licensed Embalmer's Statement on Reverse Side)

Wm
Wrensberg W C.
3548 S. Grand
Melba Bldg
2 - 3 30 PM.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, THOS. KUTIS., or by

Registered Apprentice No. ....., working under my personal supervision.

Signed Thos Kutis

Licensed Embalmer No. 1619

P. O. Address 2906 Gravois Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.