

No. 2
1-4-41
17-39
X26390

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute to City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ********
(Specify whether years, months or days) **10 years**

3. (a) PRINT FULL NAME **SADIE BELLE WEBER**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Fred** 6. (c) Age of husband or wife if alive **39** years

7. Birth date of deceased **November 11, 1904**
(Month) (Day) (Year)

8. AGE: Years **36** Months **7** Days **13**
If less than one day hr. min.

9. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)

10. Usual occupation **housework**
at home

11. Industry or business _____

12. Name **Davis**

13. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Fred Weber**
(b) Address **2204a Chouteau Avenue**

17. (a) **Removal** (b) Date thereof **June 26, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Connellsville, Penna**
(d) Signature of funeral director **A.W. McLaughlin**
(b) Address **2301 Lafayette Avenue**
(a) **JUN 26 1941** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **1722**
(d) Street No. **2204a Chouteau Avenue**
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
[Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **24**
year **1941** hour **10** minute _____ p.M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Acute Stenosis
Due to **Chronic Myocarditis**

Due to **[Signature]**

Other conditions **[Signature]**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **[Signature]**

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **[Signature]** (M.D. or other) _____
Address **[Signature]** Date signed **6/24/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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, or by.....

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

Signed L.R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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

If this body is not embalmed, fact should be so stated above.