

No. 2  
-1-4-41  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

23231  
State File No. 6089  
Registrar's No.

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:  
City Hosp. #10  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 hours  
(Specify whether  
In this community 55 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5211 Conde Str.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
No Attending Physician

3. (a) PRINT FULL NAME SEBASTIAN WEISS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month July day 17  
year 1942 hour 11 minute 30 A. 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.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Barbara Weiss  
6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased Nov. 25, 1883  
(Month) (Day) (Year)

Immediate cause of death Cerebral Apoplexy  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>7</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Watchman

11. Industry or business Bussman Mfg. Co.

12. Name Mathew Weiss

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

14. Maiden name Katherine Habschmidt

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

16. (a) Informant Mrs. Barbara Weiss

(b) Address 5211 Condie Str

17. (a) Burial (b) Date thereof 7/20/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director W. J. ...  
(b) Address 2117 E. Grand Blvd.

19. (a) JUL 18 1942 (b) J. F. ...  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_ (or means of injury)  
23. Signature W. J. Kerry (M. D. or other)  
Address \_\_\_\_\_ Date signed 7/18/42

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

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**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 *Frank A. Moore*.....

Licensed Embalmer No. *3041*.....

P. O. Address *2117 E. Grand*.....

**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.**