

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *8*

DEPARTMENT OF THE CENSUS  
**FILED MAR 11 1943**

Registration District No. *78*

Primary Registration District No. *200*

Registrar's No. *244*

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Wallston, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
6305 Lenox  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Wallston  
(If outside city or town limits, write "RURAL.")  
(d) Street No. 6305 Lenox  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Joseph Anthony Wieneck

3. (b) If veteran, name war..... 3. (c) Social Security No. 489-10-2936

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Dorothy Wieneck 6. (c) Age of husband or wife if alive 2 years  
7. Birth date of deceased March 11, 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 11 9 ..... hr. .... min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance

11. Industry or business Fulton Iron Works

MOTHER FATHER { 12. Name John Wieneck  
13. Birthplace Germany  
(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 Dorothy Wieneck

(b) Address 6305 Lenox

17. (a) Burial (b) Date thereof 2/23/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Edith E. Ambruster

(b) Address 4254 Manchester

19. (a) FEB 22 1943 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20  
year 1943 hour 5.35 P.M. minute..... M.

21. I hereby certify that I attended the deceased from Nov 2  
1943 to Feb 20 1943  
and that death occurred on the date and hour stated above.  
that I last saw him alive on Feb 16 1943

Immediate cause of death apoplexy cerebral Duration 6 hrs  
degenerative chronic myocarditis 3 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....  
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) no  
Address 539 n 9 road Date signed Feb 22/43

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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..... *Henry Cayre*

Licensed Embalmer No. *1284*

P. O. Address..... *St. Louis Mo*

**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.**