

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11570**

FILED **APR 15 1943**
Registration District No. **101**

Primary Registration District No. **101**

Registrar's No. **652**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Louis County Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 days**
(Specify whether years, months or days)

In this community **11 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**

(c) City or town **Glencoe**
(If outside city or town limits, write "RURAL")

(d) Street No. **Babler State Park Rd. Box 379**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Fred Weber**

3. (b) If veteran, name war **?**

3. (c) Social Security No. **?**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **15** year **1943** hour **6** minute **:00P.** M.

21. I hereby certify that I attended the deceased from **3-4-43**, 19, to **3-15-43**, 19, that I last saw him alive on **3-15-43**, 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 **Widower**

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

7. Birth date of deceased **Aug. 15 1876**
(Month) (Day) (Year)

Immediate cause of death: **hypertensive cardiac-vascular disease**

8. AGE:	Years	Months	Days	If less than one day
	66	7	0	hr. min.

Due to **Bilateral spastic hemiplegia**

Due to **Cerebral hemorrhage**

9. Birthplace **St. Louis County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer & U.P. Laborer**

11. Industry or business **OWN FARM**

Other conditions **Decubitus ulcer and hips**

(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name **Frank Weber**

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

14. Maiden name **Ida Paubel**

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

Major findings: Of operations.....

Of autopsy **13/10**

16. (a) Informant **Ma Sena Steffan**

(b) Address **Glencoe Mo. R. 1.**

17. (a) **Burial** (b) Date thereof **Mar-19-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Antioch Cem, Monarch, Mo**

18. (a) Signature of funeral director **Schraden Funeral Home**

(b) Address **Ballwin, Mo.**

19. (a) **MAR 22 1943** (b) **S. D. Mc. Yarnau**
(Date received local registrar) (Registrar's signature)

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)

(c) Means of injury.....

23. Signature **George S. Loggeman** (M. D. or other) **M. D.**

Address **St. Louis County Mo** Date signed **3-16-43**

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

76
2
3

R

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.....

Theo. Schrader

Licensed Embalmer No.....

3066

P. O. Address.....

Ballwin, 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.