

FILED JAN 12 1944  
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County.....*St Louis*

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

(c) Name of hospital or institution:  
**BARNES HOSPITAL 0**  
(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)

3. (a) PRINT FULL NAME *Jacob John Waible*

(b) If veteran, name war.....*None*

3. (c) Social Security No. *552-70-586*

4. Sex *M* 5. Color or race *W*

6. (a) Single, widowed, married, divorced *W*

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased. *Sept 27 1866*  
(Month) (Day) (Year)

8. AGE: Years *77* Months *3* Days *1* If less than one day..... min.

9. Birthplace *Bellville Ill. 1*  
(City, town, or county) (State or foreign country)

10. Usual occupation *Carpenter*

11. Industry or business *None*

12. Name *Martin Waibel 9*

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

14. Maiden name *? 9*

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

16. (a) Informant *Theresa Waibel*

(b) Address *Crestland Mo*

17. (a) *removal* (b) Date thereof *12/30/43*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Bellville Ill.*

18. (a) Signature of funeral director *J. F. Busch*

(b) Address *Crestland Mo*

19. (a) *DEC 30 1943* (b) *J. F. Busch*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *St Louis 96*

(c) City or town.....*St Louis 2*  
(If outside city or town limits, write "RURAL")

(d) Street No. *RR Clayton Mo. N.R.*  
(If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *28*  
year *1943* hour *10* minute *45 AM*

21. I hereby certify that I attended the deceased from *Dec 26*  
..... 19*43*, to *Dec 28*, 19*43*  
that I last saw him..... alive on *Dec 28*, 19*43*  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
*Branchopneumonia, m.*  
*middle + lower, r. + l. lower lobes*  
Due to *Arteriosclerotic Heart*  
*Disease*  
Due to *Hypertensive Cardiovascular*  
*Disease*

Other conditions.....  
(Include pregnancy within 3 months of death)

Duration

Major findings:  
Of operations.....  
Of autopsy *Bilateral bronchopneumonia,*  
*all myocardial infarct coronary sclerosis*

PHYSICIAN

Underline the cause to which death should be charged statelally.

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 *M. C. Abney 0* (M. D. or other)  
Address *BARNES HOSPITAL 0* Date signed *12/28/43*

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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 *Al C. Ortman*.....

Licensed Embalmer No. *3478*.....

P. O. Address.....

**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.**