

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1137
Registrar's No. 873

FILED FEB 4 1944 **818**

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH: St. Louis, Mo.
(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED: 000 17
(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4434 Laclede Ave. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Henry Weyl
(b) If veteran, name war None (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nannie Weyl 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased November 15 1872
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Undertaker

11. Industry or business _____

MOTHER FATHER { 12. Name Fred Weyl
13. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Ann Black
15. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Nannie Weyl
(b) Address 4434 Laclede Ave.

17. (a) Removal (b) Date thereof 1-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrenceville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe, Inc.
(b) Address 4700 Washington Blvd.

19. (a) JAN 28 1944 (b) J. F. Budek
(Date of recording) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 27th
year 1944 hour 4:20 minute P. M.
21. I hereby certify that I attended the deceased from January 20th 1944, to January 27th 44
that I last saw h. im alive on January 27th 44
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration _____
Due to _____
Due to _____
Other conditions Tuberculous meningitis
(Include pregnancy within 3 months of death)
Major findings: Hypertensive cardiovascular disease
Of operations none
Of autopsy same
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? _____

23. Signature Frank J. ... (Specify type of place) (e) Means of injury _____
Address 1515 Lafayette (M. D. or other) MD
Date signed 1/27/44

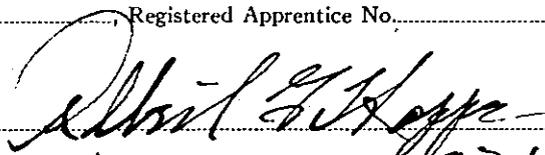
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed..... .....

..... Licensed Embalmer No..... 2971

..... 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.