

FILED MAP 6 1944 8

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 1901

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: Missouri Baptist Hospital
(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 Frank William Breitweiser

3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella Breitweiser 6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased March 18 1903
(Month) (Day) (Year)

8. AGE: Years 40 Months 11 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Dairyman

11. Industry or business _____

12. Name Fred Breitweiser

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

14. Maiden name Lillie ROSS

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

16. (a) Informant Ella Breitweiser

(b) Address Jerseyville, Ill.

17. (a) Removal (b) Date thereof 2-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) FEB 25 1944 (b) J. Thredwell
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jersey
(c) City or town Delhi
(If outside city or town limits, write "RURAL") NR
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25
year 1944 hour 12:45 minute A. M.

21. I hereby certify that I attended the deceased from 2/1-44 19 to 2/25-44 19
that I last saw him alive on 2/25/44 19
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Hyperemia

Due to Cholera Refractoria - Hemolytic

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

Major findings: Of operations _____

Of autopsy _____

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: R. K. Anderson (M. D. or other) _____

Address 4932 Maryland Date signed 4/4

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

MOTHER FATHER

Duration
PHYSICIAN
—
Underline the cause to which death should be charged statistically.

DEC 13 1945

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

Albert J. Hopper

Licensed Embalmer No. *1861*

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.