

FILED OCT 13 1944 318

Registration District No. 1003 Primary Registration District No. 1003 Registrar's No. 8402

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

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:
Lutheran 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade

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

(d) Street No.....
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Michael Weber

3. (b) If veteran, name war None

3. (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 Katherine Weber 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased July 14 1885
(Month) (Day) (Year)

8. AGE: Years Months Day If less than one day

59 2 17 18 hr. min.

9. Birthplace Unknown Hungary
(City, town, or county) (State or foreign country)

10. Usual occupation Meat Cutter

11. Industry or business Self

MOTHER FATHER { 12. Name Michael Weber

13. Birthplace Unknown Hungary
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Bitto

15. Birthplace Unknown Hungary
(City, town, or county) (State or foreign country)

16. (a) Informant Matthew Stitzel

(b) Address 3454 Oregon

17. (a) Burial (b) Date thereof 10-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bland, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) OCT 2 1944 (b) J. J. Bredel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1
year 1944 hour 1:00 minute A. M.

21. I hereby certify that I attended the deceased from Sept 20
1944 to out 1 1944
and that death occurred on the date and hour stated above.

Immediate cause of death leucemia of liver

Due to Jamieson

Other conditions Hb
(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 A. M. Grant (M. D. or other) MD

Address The S. I. Franklin Bldg Date signed Oct 2

Duration
—

3 wks

PHYSICIAN
—

Underline the cause to which death should be charged statistically.

FEB 11 1948

DEC 14 1944

MAY 28 1953

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.....

John Agosinski

..... Licensed Embalmer No. *3398*.....

..... 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.