

FILED NOV 4 1944

Registration District No. 3147

Primary Registration District No. 6076

Registrar's No. 2231

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

6
50

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
817 Allegheny drive
(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 Walter N. Weiskirch

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 3 divorced

6. (b) Name of husband or wife Katheryn C.

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

7. Birth date of deceased: November 20 1866
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace: Milwaukee Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace 7 Normal St. Milwaukee
(City, town, or county)

16. (a) Informant T. Norman Weiskirch

(b) Address 817 Allegheny Drive

17. (a) BBurial (b) Date thereof: Nov. 2, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Trinity Luth. Cem.

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 781 S. Broadway

19. (a) NOV 2 1944 (b) E. J. McLaughlin M.D.
(Date received local registrar) (Registrar's signature) City

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Lemay 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. 817 Allegheny Drive.
(If rural, give location) NO

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month October day 30
year 1944 hour 5 minute 25 P.M.

21. I hereby certify that I attended the deceased from _____, 1944 to Oct 30, 1944
that I last saw him alive on Oct 28, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Duration 3 1/2 years

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

(Specify type of place) _____
(e) Means of injury 0

23. Signature Paul R. Honeglum (M.D. or other) _____
Address 116 Lemay Ferry Rd Date signed 10/31/44

*C. P. Koenigsmann
Embalmer & Preparator*

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 *Harry J. Schumacher*
Licensed Embalmer No. *2679*
P. O. Address *732 Lemay*

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.