

NO. 2
M-843
7-5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U.S. GOVERNMENT PRINTING OFFICE: 1945
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8369
2275
State File No.

Registration District No. **318** Primary Registration District No. **1003** Registrar's No.

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: Jewish 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 St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5172 Cates ave
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Fannie Weir Weir
3. (b) If veteran, name war no 3. (c) Social Security No. no
4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Nathan Weir
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 5, 1877
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 8
year 1945 hour 8 minute 30 P. M.
21. I hereby certify that I attended the deceased from 3/7
1945 to 3/8 1945
that I last saw her alive on 3/8 1945
and that death occurred on the date and hour stated above.
Immediate cause of death _____
cardiac decompensation 2 d.
Due to arteriosclerotic heart disease (coronary type) _____ years.
Due to _____

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>1</u>	<u>3</u>	hr. _____ min. _____

Other conditions Cerebral embolism 6 weeks.
(Include pregnancy within 3 months of death)
with left hemiplegia
Major findings: _____
Of operations _____
Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace St. Louis
(City, town, or county) (State or foreign country)
10. Usual occupation at home
11. Industry or business _____
12. Name Raphael Hermah Stahl
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Rosa Block
15. Birthplace Germany
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Rose Hirsch
(b) Address 5172 Cates
17. (a) burial (b) Date thereof 3/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Heb. Berger Memorial
18. (a) Signature of funeral director _____
(b) Address 4715 McPherson ave.
19. (a) J. R. Buseck (b) _____
(Date of local residence) (Registrar's signature)

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 David Feldman (M. D. or other) MD
Address Jewish Hospital Date signed 3/8/45

(Licensed Embalmer's Statement on Reverse Side)

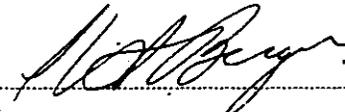
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

CVS 21340

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..... 

Licensed Embalmer No. 1597

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.