

S. No. 2
M-5-43
5-17-39
I X3867

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29467**

FILED OCT 12 1945
318

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. **8328**

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:
De Paul Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **26 Days**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **17 20**
(d) Street No. **2343 University St.** 9
(If rural, give location) **1**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Anna Weber**

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 **Married**
6. (b) Name of husband or wife **Julius Weber**
6. (c) Age of husband or wife if alive **76** years
7. Birth date of deceased **Aug. 13 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 **1** **11** hr. min.

9. Birthplace **St. Louis** **Mo.** 0
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Steger**

13. Birthplace **Unknown** 4
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Romsiheneer**

15. Birthplace **Unknown** 6
(City, town, or county) (State or foreign country)

16. (a) Informant **Julius Weber** 1

(b) Address **2343 University St.**

17. (a) **Burial** (b) Date thereof **9-28-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Goodhart & Goodhart**

(b) Address **2228 St. Louis, Ave.**

19. (a) **SEP 26 1945** (Date received local registrar)
J. F. Bredbeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **24**
year **1945** hour **7** minute **20 AM**

21. I hereby certify that I attended the deceased from **Aug 22**, 19 **45** to **Sept 24**, 19 **45**
that I last saw h. **alive on Sept. 23**, 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** **27 days**
Due to **Hypertension** **year**
Ch. nephritis **year**

Other conditions (Include pregnancy within 3 months of death) **131**

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Richard Swell** (M. D. or other) **MD**
Address **2202 Laurent** Date signed **9/24/45**

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

844

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 Maizie A. Cashin
Licensed Embalmer No. 3949
P. O. Address St. Louis Mo

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.