

S. No. 2
OM-5-43
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32488
State File No. 9368
Registrar's No.

FILED NOV 10 1945
318
Registration District No.

Primary Registration District No. 1003

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:
Bethesda 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 _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1728 S. 10th Street
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME PETER WEINHARDT

3. (b) If veteran, name war No

3. (c) Social Security No. 500-24-6500

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased November 17, 1895
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26th year 1945 hour _____ minute 13 - P.M.

21. I hereby certify that I attended the deceased from 8-20 1945 to 10-26 1945
that I last saw h. wt alive on 10-26 1945
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>11</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death Adeno-Carcinoma Anterior to Lumbar spine

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Michael Weinhardt

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

14. Maiden name Katherine Luct

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Nicholas Weinhardt

(b) Address 1728 S. 10th Street

17. (a) Burial (b) Date thereof Oct. 29, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS. Peter & Paul

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? _____

18. (a) Signature of funeral director Wm C. Moydell

(b) Address 1926 Allen Avenue

19. (a) OCT 29 1945 (Date received local registrar)

J. J. Bredeek (Registrar's signature)

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature H. J. Moore (M. D. or other)

Address 1921-50th Date signed 10-27-45

(Licensed Embalmer's Statement on Reverse Side)

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

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17
9

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..... *Bernard L. Dorman*

..... Licensed Embalmer No. *2272*

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.