

No. 2
-1/47
17-39

FILED JAN 9 1948

1003

11961

Registration District No. 318

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution.....
(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..... **Mo** (b) County..... **000**

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

(d) Street No..... **1511 r Cassave**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Francis B. Wess**

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced..... **S.O**

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

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

7. Birth date of deceased..... **Nov 5 1879**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
68	1	24 hr. min.

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

10. Usual occupation..... **Unemployed**

11. Industry or business.....

12. Name..... **Charles Wess**

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

14. Maiden name..... **Marie Jackson**

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

16. (a) Informant..... **Wm B Wess**

(b) Address..... **1511 Cass ave**

17. (a) **Burial** (b) Date thereof..... **12/31/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **St Peter's Cemetery**

18. (a) Signature of funeral director..... **Central Und Co**

(b) Address..... **1841 Cass ave**

19. (a) **DEC 30 1947** (b) **J. T. Bredek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **Dec** day..... **29**
year..... **1947** hour..... **7** minutes..... **30 P.** M.

21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Chronic Myocarditis
Primary Egestion

Due to.....

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

Underline the cause of 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)

Means of injury.....

23. Signature..... **Edith Mary** (M. D. or other) **2**

Address..... **City of St Louis** Date signed..... **12/30/47**

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

MOTHER FATHER

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

Ernest W. Spillard

Licensed Embalmer No. _____

4080

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 11961

Registration District No. 318

Primary Registration District No. 1003

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:

(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 Francis W. West

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 68 Months 1 Day 5 If less than one day
.....hr.min.

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

10. Usual occupation Unemployed

MOTHER FATHER

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) J. F. Brodeur (Registrar's signature)
JAN 11 1946

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 29 year 1945 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....

that I last saw him..... alive on....., 19..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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)

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

43598

10/11/59