

No. 300
-10-47
5-17-39
I 3906

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10807**
Registrar's No. **3306**

FILED APR 12 1948

318

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital—Max C. Starkloff
(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 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 719 Soulard St
Memorial (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Esther Weber aka Esther Hroner

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Joseph Weber
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased October 1883
(Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 0
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Weber
(b) Address 719 Soulard St.

17. (a) Burial (b) Date thereof 4-6-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Gregg E. Bras
(b) Address 6409 Grayoia Ave

19. (a) APR 6 1948 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd
year 1948 hour 12 minute 45 A. M.
21. I hereby certify that I attended the deceased from 4/1/48
....., 19....., to April 3rd, 19 48
that I last saw h. er alive on April 3rd, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure
Due to Coronary heart disease
(Diathermy treated on Sept 2
Due to defect) & arteriosclerosis
Ischemic heart disease
Other conditions Anemia
(Include pregnancy within 3 months of death)
Major findings: Secondary
Of operations.....
Of autopsy.....
PHYSICIAN 157
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?.....

23. Signature Paul J. ... (Specify type of place) (M. D. or other)
Address 1515 Lafayette Date signed 4/3/48

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 Homer W. Fritz

Licensed Embalmer No. 3882

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.