FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 6 1948

Registration District No. 317

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 21647

Registrar's No. 1422

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Overland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3537 Marshall Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 47 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis 96
(c) City or town: Overland 13
(If outside city or town limits, write "RURAL")
(d) Street No.: 3537 Marshall Ave. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) D
If yes, name country

3. (a) PRINT FULL NAME: Clarence E. Weis
3. (b) If veteran, name war:
3. (c) Social Security No.: 490-22-8197
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Dorothy
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: August (Month) 28 (Day) 1900 (Year)

8. AGE: Years	Months	Days	If less than one day
47	9	8	..... hr. ..... min.

9. Birthplace: St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Grocery Clerk
11. Industry or business:
MOTHER FATHER
12. Name: Christ E. Weis
13. Birthplace: Ellisville, Missouri (City, town, or county) (State or foreign country)
14. Maiden name: Christina Hartman
15. Birthplace: St. Louis (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Mrs. Dorothy Weis
(b) Address: 3537 Marshall
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/9/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: Louis H. Bopp, Inc.
(b) Address: 131 W. Argonne Dr., Kirkwood
19. (a) 6-8-48 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6th year 1948 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from 1935, 19..., to June 6, 1948, 19...; that I last saw him alive on May 27, 1948, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion.	
Due to: 131	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Chronic interstitial nephritis and hypertension.	1 year
Major findings: Of operations: ----------	
Of autopsy: ----------	

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

23. Signature: [illegible] M.D. (M. D. or other)
Address: 320 Metropolitan Bldg. Date signed: 6/7/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

OCT 8 1948

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 Peter B. Dubroulle

Licensed Embalmer No. 3 6 9 1

P. O. Address Richmond Heigh

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.