

No. 10-47
17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

34829

FILED NOV 6 1948
318

State File No. _____

Primary Registration District No. 1003

Registrar's No. 9327

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:
4067a Chouteau Ave.
(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 _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4067a Chouteau Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dr. JOHN W. WEIS

3. (b) If veteran, name war None 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Philomena 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Aug. 21 1897
(Month) (Day) (Year)

8. AGE: Years 51 Months 2 Days 5 If less than one day hr. _____ min. _____

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

10. Usual occupation Dentist

11. Industry or business _____

12. Name Dr. John M. Weis

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

14. Maiden name Margaret Wilcox

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

16. (a) Informant Dr. John M. Weis

(b) Address 4067a Chouteau Ave.

17. (a) Burial (b) Date thereof 10-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Und. Co

(b) Address 4228 S. Kingshighway Bl.

19. (a) OCT 28 1948 (b) J. B. Lavater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26
year 1948 hour 2:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from 9-20
1948 to 10-26 1948
that I last saw him alive on 10-25 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho genie Ca. lung
2 liver metastases Duration 3 mos.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None (pieces of liver (needle))
Of autopsy as above
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) None

(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 John J. Hammond (M. D. or other) Dr. J.
Address 1634 N. Grand Date signed 10/28/48

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

MOTHER FATHER

Dr. John J. Hammond
No. 4 State Bldg.

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 Edwin M. Bennett

Licensed Embalmer No. 3024

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.