

STANDARD CERTIFICATE OF DEATH

State File No. **38763****9716**

National Office of Vital Statistics

FILED NOV 19 1948

Registration District No. **318**Primary Registration District No. **1003**

Registrar's No. _____

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:
Enroute to St. Louis City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days 3 (Specify whether)

3. (a) PRINT FULL NAME Arnold H. Weisberger

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

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 July 12 1894
 (Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation Tool & Dye Maker

11. Industry or business _____

12. Name Wesdelin Weisberger

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

14. Maiden name Mary Grewe
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Albert Weisberger
 (b) Address Delphos, Ohio

17. (a) Removal (b) Date thereof 11/7/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lima, Ohio

18. (a) Signature of funeral director: Albert H. Hoppe

(b) Address 4700 Washington Bldg

19. (a) NOV 8 1948 (b) J. B. Loser
 (Date received local registrar's) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5118 Kensington Avenue.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 6
 year 1948 hour 8:25 minute A. 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 925 Duration _____

Due to Chronic Myocarditis

Due to Mitral Regurgitation

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

Major findings:
 Of operations _____

Of autopsy _____

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 _____

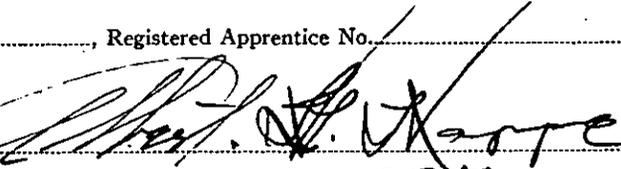
23. Signature Albert H. Hoppe (Date or other) _____

Address _____ Date signed _____

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 

Licensed Embalmer No. 2971

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.

State File No. Die
Registrar's No. 9716

Registration District No. 318

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:
(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 Arnold H Weisgerber

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 154 Months Days If less than one day hr. min.

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

10. Usual occupation.

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) 11-8-194 (b) J B Sarator (Date received local registrar) (Signature of registrar)

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 July Year 1948 hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from July 12 to July 12, 1948; that I last saw him alive on July 12 and that death occurred on the date and hour stated above. Immediate cause of death Heart Duration

Due to.

Due to.

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

Major findings: Of operations.

Of autopsy.

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).

(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 (M. D. or other)

Date signed

SUPPLEMENTARY

MOTHER FATHER

USE OF WRITING BLACK INK—MAKE A PERMANENT RECORD

NOV 28 1948

38763