

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17794

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4481**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION. St. Anthony's Hosp.		d. STREET ADDRESS (If rural, give location) 8318 Alabama Ave.,	

3. NAME OF DECEASED (Type or Print) Julia Weik			4. DATE OF DEATH (Month) (Day) (Year) May 19, 1949		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 27, 1875	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 22 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? 0

13a. FATHER'S NAME Unk	13b. MOTHER'S MAIDEN NAME Unk	14. NAME OF HUSBAND OR WIFE Fred J. Weik
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Clifford L. Miller	ADDRESS 8318 Alabama
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs 5 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive heart disease DUE TO (c) arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 930
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 44 3X
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22. I hereby certify that I attended the deceased from **May 15, 1949**, to **May 19, 1949**, that I last saw the deceased alive on **May 19, 1949**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Declarator title) George A. O'Sullivan	23b. ADDRESS 2421 N. Schermer	23c. DATE SIGNED 5-20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-21-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem.	24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.
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DATE REC'D BY LOCAL REG. MAY 20 1949	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd.,
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

See reverse side of certificate

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *David Lee Johnson*

Licensed Embalmer No. *4242*

P. O. Address *6322 So Geo*

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.