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

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35690

BIRTH NO. 77561 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8803

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place): LIFE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 2862 Wisconsin Ave

3. NAME OF DECEASED (Type or Print) a. (First): WILLIAM b. (Middle): c. (Last): WEBER
4. DATE OF DEATH (Month) (Day) (Year): Oct. 11th, 1949
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 2-7-1879
9. AGE (In years last birthday): 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labourer - (Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St Louis Mo
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Nettie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Nettie Weber ADDRESS: 2862 Wisconsin Av

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/27/49, 19__, *to* Oct. 11th, 1949, 19__, *that I last saw the deceased alive on* Oct. 11th, 1949, 19__, *and that death occurred at* 8:20am *m., from the causes and on the date stated above.*

23a. SIGNATURE: John W. Murphy Jr M.D. (Degree or title)
23b. ADDRESS: 1515 Lafayette
23c. DATE SIGNED: 10/11/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-14-49
24c. NAME OF CEMETERY OR CREMATORY: Valhalla
24d. LOCATION (City, town, or county) (State): St. L. County Mo

DATE REC'D BY LOCAL REG. OCT 13 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Allen W. McLaughlin ADDRESS: 2301 Lafayette

(Licensed Embalmer's Statement on Reverse Side)

Ind

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 C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette St

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

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