

FILED MAY 11 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15102  
State File No. 3796

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
c. LENGTH OF STAY (In weeks) <u>1 Day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>7424 West Florissant</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>William</u>	b. (Middle) <u>C</u>	c. (Last) <u>Weckback</u>	(Month) <u>April</u>	(Day) <u>24</u>	(Year) <u>1950</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 11, 1889</u>	9. AGE (In years last birthday) <u>61</u>	10. UNDER 1 YEAR Months <u>0</u> Days <u>13</u>	11. UNDER 24 HRS. Hours <u>1</u> Min. <u>13</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Schaeffer Elec</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles Weckback</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Hughes</u>	14. NAME OF HUSBAND OR WIFE <u>Bertha Weckback</u>
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bertha Weckback 7424 West Florissant</u>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) <u>Hypertension</u>		
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) <u>St. Louis Missouri</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Feb 3, 1950, to April 24, 1950, that I last saw the deceased alive on Mar. 30, 1950, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Albert Wall M.D.</u>	23b. ADDRESS <u>5322 Helen Ave</u>	23c. DATE SIGNED <u>4/24/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Apr 27 50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>	24d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>APR 25 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Facator</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fendler Und., Co 7420 Michigab Ave.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Handwritten mark*

**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 *J E Morris* .....

Licensed Embalmer No. *3360* .....

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.