

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6851**

WED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1230**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2709	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 20 2002 St. Louis Ave.	
3. NAME OF DECEASED a. (First) MATILDA (Type or Print)		c. (Last) WEBER	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH 9-12-1905	
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress Cafe		11. BIRTHPLACE (State or foreign country) Franklin Co Ill	
12. CITIZEN OF WHAT COUNTRY? US		13a. FATHER'S NAME Henry Weber	
13b. MOTHER'S MAIDEN NAME Sophia Heifro		14. NAME OF HUSBAND OR WIFE None.	
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 Mrs. A. Kirkpatrick Mulkeytown		ADDRESS	

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gangrene of Ileum with Perforation Due to Adhesions		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)		
		DUE TO (c)		
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 Gangrene of Terminal Ileum with perforation due to adhesions		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 578X 5, 12	

22. I hereby certify that I attended the deceased from **2-1-52**, 19___, to **2-5-52**, 19___, that I last saw the deceased alive on **2-5-52**, 19___, and that death occurred at **8:00A** m., from the causes and on the date stated above.

23a. SIGNATURE Jack Hilgers M.D.		(Degree or title)		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 2-5-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-5-52		24c. NAME OF CEMETERY OR CREMATORY Mulkeytown		24d. LOCATION (City, town, or county) (State) Mulkeytown Ill	
DATE REC'D BY LOCAL FEB 8 1952		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Robert H. Rowland		ADDRESS 1104 Marchant	

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

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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed.....

Licensed Embalmer No.....

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.