

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12491**
Registrar's No. **2843**

MAR 31 1953

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|-----------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 2843 | | | |
| 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 | | c. LENGTH OF STAY (In this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 2109 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 4033a Pleasant St. | | | | d. STREET ADDRESS (If rural, give location) 4033a Pleasant St. | | | | 10 | |
| 3. NAME OF DECEASED (Type or Print) Elizabeth | | a. (First) | | b. (Middle) | | c. (Last) Weible | | | |
| 4. DATE OF DEATH March 15, 1953 | | (Month) | | (Day) | | (Year) | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH May 10, 1862 | | | |
| 9. AGE (In years last birthday) 90 | | IF UNDER 1 YEAR Months _____ | | IF UNDER 1 YEAR Days _____ | | IF UNDER 1 YEAR Hours _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Self | | 11. BIRTHPLACE (State or foreign country) Iron County, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13a. FATHER'S NAME Walter Moses | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE William Weible | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | (If yes, state war or dates of service) None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME Miss Irene Weible, 4033a Pleasant | | | |
| 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 | | | | | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure | | INTERVAL BETWEEN ONSET AND DEATH 6-7 mo. | | | | | | | |
| ANTECEDENT CAUSES | | DUE TO (b) Arterio Sclerotic Heart Disease | | | | | | | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (c) Fracture rt. femur Sept. 52 | | | | | | | |
| 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"/> | | | |
| 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) _____ | | | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 4200F | | | | | | | |
| 22. I hereby certify that I attended the deceased from 9-23-1952 to 3-15-1953 , that I last saw the deceased alive on 3-15-1953 , and that death occurred at 8:25A on 3-15-1953 , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE Robert Kaplan M.D. (Degree or title) | | | | 23b. ADDRESS 607 N. Paul | | 23c. DATE SIGNED 3-16-53 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 3/17/53 | | 24c. NAME OF CEMETERY OR CREMATORY Desloge, Mo. | | 24d. LOCATION (City, town, or county) (State) Desloge, Missouri | | | |
| DATE REC'D BY LOCAL REG. MAR 16 1953 | | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 No. Grand Bl; | | | | | |

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

*Dr. Albert Kaplan
University of South Calif.*

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.

Student Embalmer No.....

Signed

Robert M Murray

Student Embalmer

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo*

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.