

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **12494**
Registrar's No. **2149**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|---------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|
| 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, Missouri | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| c. LENGTH OF STAY (In this place) 1 Month | | 2269 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital | | d. STREET ADDRESS (If rural, give location) 26 2105 Palm Street | |

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|------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------|--------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| a. (First) CHARLES | b. (Middle) WILLIAM | c. (Last) WEISS | FEBRUARY 23, 1953 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 26, 1863 | 9. AGE (In years last birthday) 89 | IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Baker | 11. BIRTHPLACE (City and State or Foreign Country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |

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|-----------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------|
| 13a. FATHER'S NAME Unknown | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Deceased |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Lily Weiss, 2105 Palm Street |

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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) Cerebral arteriosclerosis | | |
| | 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. ASFD - heart failure | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input 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? 334X |

22. I hereby certify that I attended the deceased from **1-19-53**, to **2-23-53**, that I last saw the deceased alive on **2-23-53**, and that death occurred at **2:15** m., from the causes and on the date stated above.

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|----------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------|
| 23a. SIGNATURE (Degree or title) John H. Walker, M.D. | 23b. ADDRESS 1515 Lafayette Avenue | 23c. DATE SIGNED 2-23-53 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 2-26-1953 | 24c. NAME OF CEMETERY OR CREMATORY Hiram Park Cemetery |
| 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | | |

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|---------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------|
| DATE REC'D BY LOCAL REG. FEB 25 1953 | REGISTRAR'S SIGNATURE J. Carl Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son Inc. 2161 E. Fair Ave. |
|---------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

No. 200
10. 48

FILED MAR 18 1953

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 Clement M. Neary

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.