

weick
FILED NOV 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40205

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10559**

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 town) St. Louis		c. LENGTH OF STAY (in this place) 2 Days	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros Hospt		e. STREET ADDRESS 1416 Menard St	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or Print)	a. (First) Fred	b. (Middle)	c. (Last) Bleyle	4. DATE OF DEATH (Month) (Day) (Year) Nov 6 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 1886	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during week preceding illness, if retired) Maintenance Man	10b. BUSINESS OR INDUSTRY U.S. Medical Depot	11. BIRTHPLACE (City and State or Foreign Country) Dont Know	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Philip Bleyle	13b. MOTHER'S MAIDEN NAME Veronica Deifert	14. NAME OF HUSBAND OR WIFE Etta Martin Bleyle Dec.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Dont Know	17. INFORMANT'S SIGNATURE OR NAME Josephine Heil	ADDRESS 4600 S. Broadway
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	II. OTHER SIGNIFICANT CONDITIONS		
ANTECEDENT CAUSES	DUE TO (b) Coronary Sclerosis		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Arterio Sclerosis		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	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 type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) S	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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? 4201
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22. I hereby certify that I attended the deceased from 19, to 19, that I last saw the deceased alive on 19, and that death occurred at 7:30 A m., from the causes and on the date stated above.

23a. SIGNATURE Patrol E. Taylor, Coroner	23b. ADDRESS 1500 Clark	23c. DATE SIGNED 11.7.53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 9 1953	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. NOV 7 1953	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Weick Bros	ADDRESS 2201 S. Grand Blvd.
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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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W E Morris*.....

Licensed Embalmer No. *33*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above. •