

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

6605

State File No.

FILED MAR 4 1955

1003

1295

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

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| 1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) 11 hrs d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis c. CITY OR TOWN St. John 4071 d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> f. STREET ADDRESS (If rural, give location) 8921-McNulty Drive | |
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| 3. NAME OF DECEASED (Type or Print) Jean Frances Weise | a. (First) _____ b. (Middle) _____ c. (Last) _____ | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 9, 1955 |
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|--------------------------------|---|--|--|--|--|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, REMARRIED (Specify) Never Married | 8. DATE OF BIRTH Aug. 1, 1938 | 9. AGE (In years last birthday) 16 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 1 HR. Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | 10b. KIND OF BUSINESS OR INDUSTRY Ritenour Jr. High | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 0 | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Frank M. Weise | 13b. MOTHER'S MAIDEN NAME Edna Peters | 14. NAME OF HUSBAND OR WIFE XXXXXXXXXXXXXXXX |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank M. Weise 8921-McNulty Drive |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | <p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Acute viral meningitis</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Bronchopneumonia, st. lower lobe</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | INTERVAL BETWEEN ONSET AND DEATH _____ |
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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____ |
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| 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? 3401 |
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22. I hereby certify that I attended the deceased from Feb 9, 1955, to Feb 9, 1955, that I last saw the deceased alive on Feb 9, 1955, and that death occurred at 11:00 m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <i>Walter B. Kieffer M.D.</i> | 23b. ADDRESS 4500 Olive St., St. Louis (W), Mo. | 23c. DATE SIGNED 2-11-55 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE 2-12-1955 | 24c. NAME OF CEMETERY OR CREMATORY Lake Charles Park | 24d. LOCATION (City, town, or county) (State) Wellston, Mo. |
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| DATE REC'D BY LOCAL REG. FEB 11 1955 | REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> | 25. FEDERAL DIRECTOR'S SIGNATURE AND ADDRESS 2504-Woodson Rd-Overland-14-Mo. |
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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

300
48

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 *Oscar F Mueller*

Licensed Embalmer No. *30*

P. O. Address *Overland*

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.