

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 4 1957

29655

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7210**

|                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                                    |                                                                                              |                                                                                                                             |                                                                               |                                                                                      |                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                                    |                                                                                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |                                                                               |                                                                                      |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>                                                                                                                                                                                                                                                                              |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                          |                                                                                              | c. CITY<br>OR<br>TOWN <b>St. Louis</b>                                                                                      |                                                                               | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>6250 San Bonita</b>                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                                    | Length of stay in 1b                                                                         | STREET ADDRESS <b>6250 San Bonita</b> (If outside, give location)                                                           |                                                                               |                                                                                      | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MAY</b> Middle <b>WEIL</b> Last <b>KOENIGSBERG</b>                                                                                                                                                                                                                                                                    |                                  |                                                                                                                                                                    |                                                                                              | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>1</b> Year <b>1957</b>                                                       |                                                                               |                                                                                      |                                                                                       |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                               | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 8. DATE OF BIRTH<br><b>Feb. 22, 1891</b>                                                                                    |                                                                               | 9. AGE (In years last birthday)<br><b>66</b>                                         | IF UNDER 1 YEAR OF UNDER 24 HRS.<br>Months Days Hours Min.                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At home</b>                                                                                                                                                                                                                                                         |                                  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                  | 11. BIRTHPLACE (City and state or country)<br><b>Dayton, Ohio</b>                            |                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                 |                                                                                      |                                                                                       |
| 13. FATHER'S NAME<br><b>Benjamin Weil</b>                                                                                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                                    |                                                                                              | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Liptin</b>                                                                            |                                                                               |                                                                                      |                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk.</b>                                                                                                                             | 17. INFORMANT Address<br><b>J. Weil-8150 Amherst</b>                                         |                                                                                                                             |                                                                               |                                                                                      |                                                                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO (b) <b>Coronary Sclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)<br><b>420.1</b> |                                  |                                                                                                                                                                    |                                                                                              |                                                                                                                             |                                                                               |                                                                                      | INTERVAL BETWEEN ONSET AND DEATH                                                      |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |                                                                                                                             |                                                                               |                                                                                      |                                                                                       |
| 20c. TIME OF INJURY<br>Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m.                                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                                    |                                                                                              |                                                                                                                             |                                                                               |                                                                                      |                                                                                       |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                                                          |                                                                                              | 20f. CITY, TOWN, OR LOCATION                                                                                                |                                                                               | COUNTY                                                                               | STATE                                                                                 |
| 21. I attended the deceased from <b>8:10 P.</b> to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                                                          |                                  |                                                                                                                                                                    |                                                                                              |                                                                                                                             |                                                                               |                                                                                      |                                                                                       |
| 22a. SIGNATURE<br><b>James M Kelly Deputy Coroner</b>                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                                    |                                                                                              | 22b. ADDRESS<br><b>1300 Clark</b>                                                                                           |                                                                               | 22c. DATE SIGNED<br><b>8-2-57</b>                                                    |                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                           |                                  | 23b. DATE<br><b>8/4/57</b>                                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Sinai Cemetery</b>                              |                                                                                                                             | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b> |                                                                                      |                                                                                       |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Herman Rindskopf, Inc. 5216 Delmar</b>                                                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                                    |                                                                                              | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 2 57</b>                                                                             |                                                                               | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith MD</b>                                    |                                                                                       |

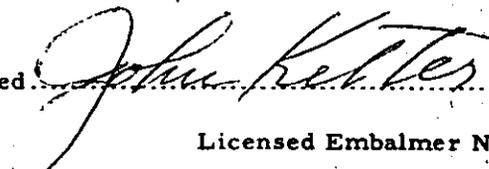
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STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.**  
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.