

pt. Health,  
, & Welfare  
S. Public  
alth Service

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ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42744

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10491**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>25 City Hospital</b>		Length of stay in lb <b>D.O.A.</b>	d. STREET ADDRESS (If outside, give location) <b>310 4157 Warne Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WILLIAM R. WALLWEBER</b>			4. DATE OF DEATH Month <b>November</b> Day <b>4th.</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1894</b>	9. AGE (In years last birthday) <b>63</b>	10. FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Joe Fitzgerald Tav.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Robert Wallweber</b>		13b. MOTHER'S MAIDEN NAME <b>Theresa Reinschmidt</b>		14. NAME OF HUSBAND OR WIFE <b>Goldie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>16 St. James Ct. Florissant, Mo.</b> <b>Mr. William H. Wallweber</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>O.K. ...</b> DUE TO (c) <b>...</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>...</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
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.) <b>331X</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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>Oct 1, '57</b> to <b>Oct 4, '57</b> and last saw <sup>him</sup> alive on <b>Oct 4, '57</b> Death occurred at <b>2:59 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>A. J. Murphy M.D.</b>			22b. ADDRESS <b>4143 N. Vandeventer</b>		22c. DATE SIGNED <b>11/5/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>November 7, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Churchyard</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc.</b>		ADDRESS <b>2161 E. Fair Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 5 57</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b> <i>SR</i>

(Licensed Embalmer's Statement on Reverse Side)

embalmed (reversed)

### 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 *Clement M. Neary*

Licensed Embalmer No. *3732*

P. O. Address *H. L. Lewis*

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.