

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034935

STATE FILE NUMBER

FILED OCT 6 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2513

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PINE LAWN</u> 4161
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY HOSP - 3-DAYS</u>		Length of stay in 1b <u>3-DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>6207 CRESTON</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jacob Jr.</u> Middle <u></u> Last <u>Weber</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR-19-1869</u>		9. AGE (In years last birthday) <u>89</u>
			IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	

10a. USUAL OCCUPATION (Give kind of work done during past of working life, or retired) <u>UPHOLSTERER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>	11. BIRTHPLACE (City and state or country) <u>BELLEUILLE-ILL 1</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>FRED WEBER</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>ANNA EVA WEBER</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>487-98-1705</u>	17. INFORMANT <u>George Weber, 6207 Creston</u>	Address <u>6207 Creston</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Artery Atherosclerosis</u>	
	DUE TO (c) <u>Generalized Arteriosclerosis 4201F</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture neck Left Femur</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>

20d. INJURY OCCURRED 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 <u>CLAYTON</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
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21. I attended the deceased from <u>9-26-1958</u> to <u>9-28-1958</u> and last saw her/him alive on <u>9-28-1958</u> Death occurred at <u>7:12 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. M. Garrison, Jr. M.D.</u> (Degree or title)	22b. ADDRESS <u>601 S. Brentwood Clayton Mo</u>	22c. DATE SIGNED <u>9-29-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>OCT-1-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis - MO</u>
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24. FUNERAL DIRECTOR <u>L.B. Tanner, 6107 Natural Bridge</u>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u></u>	26. REGISTRAR'S SIGNATURE <u>R. Dombke M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Secretary, coroner, etc., must use only standard manufacturers in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *E. Thompson*

Licensed Embalmer No. *4283*

P. O. Address *St. Louis, Mo.*

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.