Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003932

STATE FILE NUMBER

JAN 12 1959 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 53

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Wellston — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1277a Delware — Length of stay in 1b YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Wellston 4311 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1277a Delware — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: John Middle: F. Last: Weber

4. DATE OF DEATH Month 1 Day 2 Year 59

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 8-16-1905

9. AGE (In years last birthday) 53 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed

10b. KIND OF BUSINESS OR INDUSTRY Groc.

11. BIRTHPLACE (City and state or country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John F. Weber

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Elizabeth Weber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 492-12-1780

17. INFORMANT Mrs. Elizabeth Weber Address 1277a Delware Wellston, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THROAT — INTERVAL BETWEEN ONSET AND DEATH 14 YR.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 148 X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 OCT. 1, 1958, to JAN 2, 1959 and last saw ~~her~~ him alive on JAN 2, 1959
Death occurred at 11 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Orville G. [illegible] MD

22b. ADDRESS 2100 HODSON DR.

22c. DATE SIGNED 1-5-59.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1-5-1959

23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR Jos. W. Clark F.H. ADDRESS 1125 Hodiamont

25. DATE RECD. BY LOCAL REG. 1-6-59

26. REGISTRAR'S SIGNATURE Herbert R. Domke, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 John S. Kennedy

Licensed Embalmer No. 4194

P. O. Address St. Louis, 9

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.