

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008019

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 375

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital		Length of stay in lb 141 days	d. STREET ADDRESS 7617 Alabama		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle E. Last Weber Sr.			4. DATE OF DEATH February 4, 1959 Month February Day 4 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-93		9. AGE (In years last birthday) 65 IF UNDER 1 YEAR: Months 6 Days 5 IF UNDER 24 HRS: Hours 5 Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) order clerk		10b. KIND OF BUSINESS OR INDUSTRY Crane Plumbing Supply Co.		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
13. FATHER'S NAME Nick Weber			14. MOTHER'S MAIDEN NAME Louise Spahn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW-1		16. SOCIAL SECURITY NO. 488-07-3636		17. INFORMANT Records of Robert Koch Hospital Address	
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, maxillary sinus, metastasis					INTERVAL BETWEEN ONSET AND DEATH 4-30-57 56 4-4-59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Tuberculosis, far advanced					
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 Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____					
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 COUNTY STATE	
21. I attended the deceased from 7-1-58 to 2-4-59 and last saw xx him alive on 2-4-59 Death occurred at 11:35 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Axel R. Loran (Degree or title) M.D.			22b. ADDRESS Robert Koch Hospital, Koch, Mo.		22c. DATE SIGNED 2-5-59
23a. BURIAL OR CREMATION (If cremated, give date) Removed		23b. DATE Feb. 9, 1959	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo.
24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries 7814 S. Broadway		25. DATE RECD. BY LOCAL REG. 2-6-59		26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Bill C. Branson*.....

Licensed Embalmer No. *4*.....

P. O. Address *St. Louis*.....

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.